

An exploration of the facilitators and barriers experienced by Rehabilitation Care Workers in the provision of Speech – Language Therapy related services.

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Abstract

Background: South Africa experiences a severe shortage of speech-language therapists (SLTs) which results in individuals requiring Speech-Language Therapy (SLT) services having to travel long distances or being placed on long waiting lists to access services. Rehabilitation Care Workers can assist with bringing this service closer to the communities they serve. It is important to explore the experiences of these individuals to ensure that they are adequately supported and skilled. The University of Cape Town (UCT) has been training Rehabilitation Care Workers (RCWs) since 2012, however to there is currently no empirical data documenting the facilitators and barriers experienced by RCWs in their work.

Aim: To explore RCWs (in the Mitchells Plain/Klipfontein sub-structure) perceptions of the facilitators and barriers in providing SLT related activities in their work context.

Methods: A descriptive exploratory study was conducted. Eighteen RCWs were approached and 13 participated in 2 focus groups. Data was transcribed and analysed using thematic analysis. An inductive approach was used to develop meaningful themes and sub-themes.

Results: The plot of “vital role players” best synthesized the 3 main themes namely scope of practice, RCW position and value as an intrinsic motivator and challenges. : The *scope of practice* theme included 4 sub-themes namely, RCW activities; awareness of broad scope; understanding family needs; including family as stakeholders in patient management. *RCW position and value as an intrinsic motivator* - included 4 sub-themes namely, integral members of the team; agents for change; community servants; go between formal structures and the community. Finally the theme *challenges* –included 4 sub-themes namely, training gaps; safety; lack of resources; feeling undervalued. The facilitators and barriers identified by the RCW’s aligned with perceptions of other mid-level health care workers as reported in the literature.

Implications: RCWs work within a family centred care approach and see themselves as community servants who bring vital rehabilitation services into homes by transferring their skills to families and communities through education, support and advocacy. Despite their value and passion, RCWs feel undervalued by those around them, including management structures and the Department of Health (DOH).

Conclusion: RCWs can bring much needed rehabilitation services into the homes of communities in Cape Town. For this reason, it is imperative to consider the facilitators and barriers experienced by these individuals in order to harness their natural skills and strengthen the current RCW service and solidify their roles within the Multidisciplinary Team (MDT).

Chapter 1

Introduction

1.1. Background to the study

South Africa's high burden of disease has placed immense pressure on the current health care system, its resources, and the health professionals working in it. This increased pressure, together with the extreme poverty faced by many South Africans, has left many South African citizens unable to access health care in an equitable and just manner. To overcome these challenges, the National Planning Commission of South Africa proposed the National Development Plan with Healthcare 2030 as its chosen method to address these inequalities (National Planning Commission, 2011). This strategy incorporates the universally set Millennium Development Goals (MDGs) and the revised Sustainable Development Goals (SDGs) proposed by the United Nations. It is hoped that if these are attained, the result would be quality health care for all and the eradication of inequality, poverty and poor access to health care (Mannan et al., 2012; Mulaudzi et al., 2016). Phillips (2014) suggests that strengthening the current Primary Health Care (PHC) system of the country is one way to achieve both the vision of Healthcare 2030 and the Sustainable Development Goals. Primary Health Care is a public health strategy which promotes the idea that health care gains are better obtained when individuals basic health care needs are met which necessitates the need to locate the health care services as close to the community and households as possible. The principles of equity in health service delivery; access to affordable and appropriate services; empowerment of people; and sustainability and cost-effectiveness of service provision underpin this approach (Dookie & Singh, 2012).

The ethos of making health care services appropriate and accessible to the average South is greatly hindered by insufficient resourcing; notably the number of highly trained health care professionals within the health sector (Mannan et al., 2012). According to the World Health Organization (WHO, 2008) this trend of insufficient resourcing is particularly rife in the African region, which carries one quarter of the world's burden of disease, only 3% of the global health work force, and less than 1% of the world's financial resources. Zulliger, Moshabela & Schneider (2014) propose

“task-shifting” as a necessary measure to ensure the efficacy and sustainability of the PHC approach in an under-resourced health care system. This approach involves the transfer of basic skills from highly trained health professionals to mid-level workers, to make services more accessible (Mannan et al., 2012). “Task-shifting” has been earmarked as a means of providing health care services in a more accessible manner and on a larger scale, with a focus on targeting the vulnerable as it allows services to be provided closer to home (Tomlinson, Rahman, Sanders, Maselko, Rotherrum-Borus., 2014).

South Africa experiences a significant shortage of speech – language therapists (SLTs). A total of 2679 SLTs are currently registered with the Health Professions Council of South Africa (Y. Daffue, personal communication, 4 April 2018). With South Africa’s current population surpassing an estimated 56 million (Statistics South Africa, 2017) the SLT to patient ratio is approximately 1 SLT: 25 000 people. When compared with international standards which range from between 1:2500 and 1:4700 in US, UK, Canada, and Australia one can clearly see the serious under-resourcing in South Africa (McAllister et al, 2013). In addition, in 2011 the distribution of SLT services indicated that more than 50% of registered SLTs were working in private practice and in urban areas (Kathard & Pillay, 2013), therefore providing services to a limited sector of South Africa’s population. This suggests that the SLTs in the public health sector provide services to a large percentage of the general population. There are 40 SLT posts offered by the Western Cape Department of Health (WCDoH) of which 4 are vacant, resulting in 36 SLTs left to service a population of 6,510,300 (A. De Villiers, personal communication, 19 March 2018; Stats SA, 2017). One then needs to consider the negative impact on service delivery and the achievement of the Healthcare 2030 vision of the low numbers of SLTs servicing the large numbers of average South Africans, in the reality of a growing population. Until recently SLT services in the Western Cape were primarily provided at tertiary level government health care facilities and were therefore not easily accessible to many people (De Kok & Louw, 2014). As of 2018 the distribution of SLTs across levels of care are as follows: 15 in tertiary settings; 5 at district level; 4 at Intermediate Care level and 12 at a PHC level (A. De Villiers, personal communication, 19 March 2018). It is evident that there is a demand for mid-level health care workers who can assist with the provision of speech-therapy related assessment and intervention tasks at a PHC level.

1.2. Problem Statement

In keeping with the demand for mid-level trained workers, specifically in the area of rehabilitation, the Division of Disability Studies in the Department of Health and Rehabilitation Sciences at the University of Cape Town (UCT) in South Africa, embarked on the journey of creating a training program to upskill Home based Carers (HBCs) to become Rehabilitation Care Workers (RCWs); with the goal that these individuals would be based at a community level and therefore bring rehabilitation services closer to communities. Rehabilitation Care Workers have been employed by three institutions within the Mitchells Plain/Klipfontein area. These are: Life Esidimini Intermediate Care, which is an adult intermediate health care institution funded by a partnership between the public and private sectors with 1 SLT; Sarah Fox Children's Convalescent Hospital (SFCCH), which is a paediatric Intermediate Care facility with 1 sessional SLT, and the WCDoH with RCWs working in the Primary Health Care Sector (PHC) where there are currently 2 SLTs employed. For this study only RCWs working at SFCCH and those working in the PHC sector were included as these were government funded institutions. Little is known about the experiences of RCWs working in these 2 institutions. Furthermore, no other research exists in exploring the facilitators and barriers experienced by RCWs with a particular focus on the provision of Speech-Language Therapy (SLT) related activities.

1.3. Aim of the study

As the field of the RCW is still in its infancy, limited literature has explored this alternative cadre of professional, and the potential advantages of task- shifting in this context remain insufficiently documented. This study explores and describes the experiences of RCWs in providing SLT related activities (within the Mitchells Plain/Klipfontein area of Cape Town, Western Cape) with a focus on the benefits and challenges of providing such services. The aim of the research project is to explore the perceptions of Rehabilitation Care Workers (RCWs) located in the Mitchells Plain /Klipfontein sub-district, regarding the facilitators and barriers to providing Speech-Language Therapy related activities in their work context.

1.4. Definition of key terms

To better orientate the reader to the South African context, important terms used throughout this dissertation are defined below:

Alternative cadre refers to people who have received focused, shorter training than that normally received by health professionals and who undertake equivalent tasks (Mannan et al., 2012).

Community Based Rehabilitation (CBR) is a universally accepted approach to improving inclusivity and access for individuals with disability (Community Based Rehabilitation Guidelines, 2010).

Community Health Workers (CHWs) may be defined as a health worker delivering health care to communities, who has received training in the context of prevention, promotion and intervention, and having no formal professional, certificated or degreed tertiary education (Clarke, Dick & Lewin, 2008).

Family-Centered Care (FCC) is an approach to health care that fosters a partnership regarding health care decision-making between the health care service providers, patient and patient's families (Kuo et al., 2012).

Home-based carers (HBCs) may be defined as an informal health worker who provides health services in the home to promote, restore and maintain a person's maximum level of function and health. These individuals often provide preventative, promotive, therapeutic and palliative services (Western Cape Department of Health, 2013).

Intermediate care facilities refer to institutions where in-patient transitional care is the focus. Services facilitate optimal recovery from acute illness or complications of a long-term condition, enabling users to regain skills and abilities in daily living with the ultimate discharge destination being home or an alternate supported living environment (De Kok & Louw, 2014).

Mid-level Workers (MLWs) are cadres of health care workers who have been trained for short periods and require lower entry educational qualifications (Dawad & Jobson, 2011).

Mitchells Plain/Klipfontein sub-district is one of the 4 health districts in the Cape Metropole area (De Kok & Louw, 2014).

Primary Health Care (PHC) is an approach to health care originating from the social model of health and is based on the philosophy of ensuring that people's basic needs (water and sanitation, education, employment) are met to ensure better health care outcomes (Dookie & Singh, 2012).

Rehabilitation Care Workers (RCWs) are the group of CHWs in the Western Cape specifically trained to improve community-based services, which includes community and home-based care as well as intermediate level of care (Clarke, 2015) for people with existing disabilities.

Sustainable Development Goals (SDGs): These are goals identified by the United Nations as being useful for the achievement of sustainable development at the global level, with the integration of development - economic, social and environmental sustainability (United Nations, 2015).

Task-shifting is defined as the process of professionals transferring some of their skills to minimally trained individuals to address health care worker shortages (Dawad & Jobson, 2011).

Universal Health Coverage (UHC) is the vision of ensuring access to adequate and appropriate health care for all citizens of the BRICS (Brazil; Russia; India; China and South Africa) countries (Marten et al., 2014).

1.5. Abbreviations used in the study

CBR:	Community Based Rehabilitation
CHW:	Community Healthcare worker
FCC:	Family – Centred Care
HIV:	Human Immunodeficiency Virus
MDG:	Millennium Development Goals

MDR TB:	Multi-drug resistant Tuberculosis
PHC:	Primary Health Care
RCW:	Rehabilitation Care Worker
SFCCH:	Sarah Fox Children's Convalescent Hospital
SLT:	Speech-Language Therapy
SLTs:	Speech-Language Therapists
SDGs:	Sustainable Development Goals
UCT:	University of Cape Town
UHC:	Universal Health Coverage
WCDoH:	Western Cape Department of Health

1.6. Summary

This chapter provided brief background as to why this research question has been posed. Brief reference has been made to the PHC context of the country and the justification for an alternative cadre of the RCW to be formed through task-shifting. The next chapter provides a detailed discussion of the available literature relevant to this research study.

Chapter 2

Literature Review

** Racial classification terms used in this document are guided by the South African Census 2012.*

2.1. Introduction

This chapter explores current literature relating to South Africa's political history and resulting service delivery disparities. This chapter also discusses National Government's strategies to reduce these injustices through the introduction of Primary Health Care (PHC), and Community Based Rehabilitation (CBR) which have been implemented to improve access to health care for the average South African citizen, with the aim of ensuring quality health care for all. This literature review introduces the concept of Family-Centred Care (FCC) and then discusses the introduction of an alternative cadre of health care worker and the process of task-shifting as a means to achieve PHC and CBR.

2.2. South Africa's past political injustices

Racial discrimination and injustice have been a primary tenet of South Africa's history (Coovadia, Jewkes, Barron, Saunders & McIntyre, 2009). During the Apartheid regime, the government sought to segregate the country's Black South African majority from the White South African minority. Ensuring benefit for White South Africans resulted in consequent deprivation for Black South Africans as infrastructure and economic capital were often reserved for services which catered to the "elite" (Kon & Lackan, 2008). The South African Apartheid government institutionalized these inequalities through unfair labour laws and unequal investments in services for different racial groups (Sanders & Chopra, 2006). Before democracy, political, economic and land policies were dictated by race. The chronic shortage of health workers and an uneven distribution of these workers between the private and public sectors and geographical areas resulted in the poorest citizens having the lowest rates of health service use and receiving fewer benefits of health care, despite the burden of disease being far greater for this demographic (Marten et

al., 2014). This unequal access to opportunities and resources has a pervasive effect on all areas of daily living including access to health services (Coovadia et al, 2009); such that, although South Africa is considered a middle-income country (with a per capita gross domestic profit of \approx 10000 dollars), its health outcomes are considerably poorer than other middle-income countries (Sanders & Chopra, 2006).

The World Health Organisation Commission on Social Determinants of Health has recognized that the most predominant factor affecting health outcomes is social inequalities, as societal inequalities have a significant influence on the distribution of health services and that societal norms, policies and practices can promote and perpetuate systematic inequalities (Ottersen et al., 2016). Harris et al. (2011) explain that health outcomes remain significantly affected by racial, socio-economic, and rural-urban differentials and that achieving equity between the public and private health sectors remain challenging. Kon and Lackan (2008) provide empirical data to support this in a study which focused primarily on ethnic differences in access to health care and perceptions of governmental actions that impact on health amongst South Africans. This study involved analysis of the data received from the 2002 Afrobarometer survey. These results indicate that a total of 40.8% of Black South Africans and 22.9% of Coloured South Africans reported going without medical care at some point in the past year, compared with 10.9% of White South Africans and 6.9% of Asian South Africans. These disparities are perpetuated by the fact that established and well-resourced services are often concentrated in more affluent areas which are too costly for the average South African to access. Moreover, the situation does not seem to be improving. In the Afrobarometer policy paper of 2016, 29% of South African's indicated going without medicine or medical care in a year (Armah-Attoh et al., 2016). In addition, the report indicates that the average percentage of clinics in African countries is 62% with South Africa's rate of 42% being well below that (Armah-Attoh, Selormey & Houessou, 2016).

Disparities such as these exist not only in health, but also in education, income, and basic public infrastructure (Kon & Lackan, 2008). Coovadia et al. (2009) elaborate on the inequalities experienced by the Black South African and Coloured South African communities, stating that factors influencing South Africa's poor health outcomes include the historical gender disparity between men and women; high rates of unemployment leading to poverty; health inequities where prevalence of diseases

(such as HIV) is higher in Black and Coloured communities than White and Indian communities; and life expectancy, which is 50% higher for a White female than for a Black female. Tomlinson et al, (2014) go on to explain that health across the life span in low and middle-income countries such as South Africa is significantly compromised by multiple risk factors, such as the effects of poverty and related deficits from infectious diseases, nutritional deficits, and poor maternal health.

The fall of Apartheid in 1994 was seen by many as an opportunity for redress; an opportunity to correct the inequalities that marred the health care system (Stuckler, Basu & McKee, 2011). However, health care reforms in the late 1990's saw the introduction of GEAR, a growth, employment, and redistribution strategy that focused on privatization and fiscal austerity (Stuckler et al., 2011). This strategy saw government increasing expenditure to the private sector while reducing funding to the public health sector. Provinces with more equipped infrastructure and subsequently a greater White South African population gained more resources, while provinces with far greater health burdens; less resources and the largest populations of people of colour, received the least amount of investment from national public health care funds (Stuckler et al., 2011). Unfortunately, more than 20 years into South Africa's democracy; and despite a constitutional obligation to ensure the right to access health services, South Africa's health care system remains divided. The affluent are often covered by private insurance and have access to well-resourced private health care facilities while the average South African citizen is reliant on a poorly resourced public-sector (Marten et al, 2014). Mayosi and Benetar (2014) explain that an appropriate response to South Africa's health care challenges needs to be multi-faceted and should address the social determinants of health, strengthen the health care system, and facilitate universal coverage of health care (through policy reforms and the upskilling of an alternative cadre of health care worker).

2.3. The current shortage and distribution of rehabilitation professionals within the South African context

Reilly et al. (2010) state that improving access to rehabilitative services will improve the overall health outcomes of communities by contributing to sustainable patient management. Braun et al. (2013) elaborate that nearly all countries are challenged by shortages of health workers, which has significant negative impacts on the health outcomes of these countries. However, the effects of a lack of human resources is felt particularly in the world's poorest countries, where the crisis is fuelled by the migration of qualified health workers to richer countries, inadequate investment in national health systems, and the devastation of major epidemics such as HIV/AIDS, tuberculosis, and malaria. This shortage of adequately skilled health care professionals often has significant impacts on health care service provision, therefore affecting the efficacy of PHC and CBR programs. South Africa in particular, experiences a shortage of critical rehabilitation professionals hindering the effective implementation of CBR programs (Maart & Jelsma, 2013). Maart and Jelsma (2013) explored the effect of South Africa's PHC problems with an emphasis on rehabilitation services, stating that the low numbers of rehabilitation professionals working at the community level, makes access to PHC and CBR services nearly impossible for persons with disability and impaired health.

A study conducted by Kathard and Pillay (2012) explored the distribution of Speech-Language Therapy (SLT) services in South Africa and found that the ratio of patients managed by one SLT is considerably higher than most developed countries such as America and Canada. Not only are there too few SLTs to sufficiently cater to the needs of the population; but there is also an unequal distribution of this service across the public and private healthcare sectors (Pascoe & Norman, 2011). These scarce SLT services often result in individuals having to travel long distances and wait long periods to access SLT services (De Kok & Louw, 2014). Speech-Language Therapy services have historically been concentrated in tertiary settings, leaving the intermediate and PHC settings neglected, which resulted in long waiting lists for services at tertiary level institutions. De Kok and Louw, (2014) state that delayed assessment and management has a significant negative impact on therapeutic outcomes, not only for patient progress but also on the attendance of follow-up clinics.

2.4. National Government's strategies to reduce injustices in the Health Care System

Universal Health Coverage (UHC) is a shared goal amongst each of the BRICS (Brazil; Russia; India; China and South Africa) countries and is an essential tool to ensure that all citizens are able to access adequate and appropriate health care (Marten et al., 2014). To reach the goal of UHC, the South African National Government established the National Development Plan (NDP), which has as its primary aim, the eradication of poverty and the reduction of inequality for all by the year 2030 (National Planning Commission, 2011). The primary goals of the NDP include: improved management systems especially at institutional level; higher numbers of better trained health care professionals; better discretion over clinical and administrative matters at facility level; and better patient information systems supporting decentralised and Home-Based Care (HBC) models (Department of Health Western Cape, 2013). The South African government identified the positive impact that implementing a strong PHC service will have on achieving the goal of UHC, as this approach drives health care services in communities and in homes, making basic health care services more accessible to the average citizen.

Primary Health Care (PHC) is more than merely an approach to delivering health care, it is a philosophy of achieving equitable health outcomes for all and it governs all levels of care within the health system, and when seen in conjunction with efforts in other sectors may be responsible for delivering improvements to a number of the social determinants of health (Naledi, Barron & Schneider, 2011). Primary health care is driven by the purpose of bringing basic services closer to home, focusing on the prevention of disease and the promotion of good health behaviours by involving families and communities in health care decision making. It is this dynamic of PHC that allows it to be a successful measure in improving access to health care for the average South African.

The concept of Primary Health Care (PHC) is not a recent one. In 1940, the then Department of Public health spearheaded an initiative aimed at addressing the escalating burden of infectious and deficiency diseases among increasingly impoverished rural Black communities in South Africa, this project was known as the

Pholela Experiment (Phillips, 2014). Phillips (2014) go on to explain that based on the implementation and success of social medicine in Europe, China, and Dutch Java, a health centre–based system that combined the provision of free curative, preventive, and promotive medicine at one site was created. This approach not only provided care to the ill but also aimed to monitor the health of the well by encouraging regular visits to the facility and by allowing locally trained health care assistants to provide basic health care services in homes (Phillips, 2014). The success of this initial project led to the creation of 44 additional centres (Phillips, 2014). Despite the success of the Pholela Experiment, the project dwindled after the rise of the Apartheid regime. Interestingly, the new democratic ANC who was elected in 1990, used the World Health Organisations Alma Ata address (which took place in 1978) to and advocate for the reintroduction of PHC as a guide to spearheading the resurrection and revitalization of this model of health care service, which focussed on providing basic health care services in homes and readily accessible venues in the communities (Naledi et al., 2011).

Community based rehabilitation (CBR) is another approach which focussed on upskilling community members whilst simultaneously empowering and providing care to people with health conditions and their families. CBR is a globally accepted approach to improve inclusivity and access for individuals with disability. Community based rehabilitation received particular attention in the 1980s in South Africa as a result of persons with disabilities' struggle to get rehabilitation professionals to assist in the disability rights movement (Chappell & Johannsmeier, 2009). The primary objective of this approach is to meet needs in the areas of health, education, livelihood and social life, and to empower people with disabilities, their families and communities (World Health Organisation, 2010). The original directive has broadened significantly since its inception, and now includes the equalization of opportunities, poverty reduction and social inclusion of individuals with disabilities (World Health Organisation, 2010). Unlike most rehabilitation programs, which are medically focused and often institutionalized, CBR is rooted in community development and aims to facilitate inclusion in all areas of function (Chappell & Johannsmeier, 2009).

Similar to Primary Health Care, Community Based Rehabilitation has also been recognised by National Government as forming the foundation of a national

rehabilitation strategy (Chappell & Johannsmeier, 2009). However, Mannan et al. (2012) suggest that the efficacy of CBR programs are significantly hindered by the global shortage of rehabilitation professionals, particularly experienced in the African continent, and the success of such programs will rely on additional health workers with improved distribution and a new set of skills.

Both the PHC and CBR approaches fit within the Family Centred Care (FCC) framework. Coyne (2013) explains that FCC fits into the leading ideology of consumer involvement within health care, in that care is patient-centred rather than clinician-centred and consequently patients and their families are empowered in the process of accessing health services. Thus, the Family-Centred Care (FCC) approach is increasingly becoming the ideal system of care to structure the involvement of families in health care globally, but also in resource-constrained countries. Barry and Edgman-Levitan (2012 pg. 780) suggest that there are eight crucial beliefs that underpin family-centred services: “respect for the patient’s values, preferences, and expressed needs; coordinated and integrated care; clear, high-quality information and education for the patient and family; physical comfort, including pain management; emotional support and alleviation of fear and anxiety; involvement of family members and friends, as appropriate; continuity, including through care-site transitions; and access to care”. Both CBR and PHC align with many of these principles.

The FCC approach stresses the importance of better understanding the experience of illness and managing the needs of patients considering the complex nature of health care (Barry & Edgman - Levitan, 2012). Family-Centred Care involves fostering a partnership approach to joint health care decision-making (between the patient and their family and health care provider), subsequently improving clinical practice by building relationships that bridge academic, social and economic differences (Bruder, 2010; Kuo et al., 2012). It also includes family support and education, thus contributing to raising awareness of relevant health related conditions within communities (Coyne, 2013). This approach to health care has been advocated for across a range of health care disciplines and areas including early intervention; early childhood education; special education and rehabilitation services (Dempsey & Keen, 2008).

Effective PHC and CBR programmes are reliant on a strong work force of adequately trained health care professionals and health care workers. However, South Africa does not have sufficiently trained health care professionals to ensure the effective implementation of PHC and CBR. Mayosi and Benetar (2014) explain that an appropriate response to South Africa's health care challenges needs to be multi-faceted and should address the social determinants of health, strengthen the health care system, and facilitate universal coverage of health care (through policy reforms and the upskilling of an alternative cadre of health care worker). Therefore, there is a call for training of additional health care workers with a new set of skills, an 'alternative cadre' (Mannan et al., 2012).

Task-shifting has been identified as a possible means to achieving optimal PHC and CBR services as it involves health care professionals transferring skills to lesser trained health care workers (Dawad & Jobson, 2011). This process has been particularly successful in countries where a lack of human resources is a critical barrier to service delivery (Zulliger et al., 2013). Countries such as, Brazil, Ethiopia, Malawi, Mozambique and Zambia have successfully demonstrated the positive impact on health care outcomes that task shifting can have on building sustainable, cost-effective and equitable health care systems (Lehman, Van Damme, Barten, Sanders, 2009). Callagan et al. (2010) elaborate that there has been support for the general conclusion that good health outcomes can be achieved by shifting some tasks from highly trained professionals to lay community members or community health workers. Callagan et al. (2010) add that non-physician health care workers are able, with careful training and supervision, to deliver equal and sometimes better results than doctors. Consequently, there is considerable interest regarding the possibility of shifting tasks from professionals or midlevel workers to lay or community health workers. South Africa has identified task shifting as a potential means to achieve successful PHC and CBR programs whilst maintaining the principles integral to the strategies of universal health care access namely equity participation and integration. In addition, the use of task-shifting to create an alternative cadre of health care worker has been identified, as pivotal in the realization of the goal of UHC, in light of the country's significant human resource shortage (National Planning Commission, 2011).

2.5. Using task-shifting to create an alternative cadre of health care worker

Community Health Workers were internationally recognised in the Alma Ata conference in 1978 as a strategy to achieving health care for all (Mwita, 2010). The South African government have emphasised the importance of CHWs in the revitalised PHC and CBR strategies as these individuals are able to ensure greater coverage of health care services by bringing health care into homes and communities (Mayosi & Benetar, 2014; National Planning Commission, 2011). These are health care workers with limited training who live in the communities they serve and form a critical link between these communities and the PHC system and as such are able to improve the relevance, acceptability and accessibility of health services (Braun, Catalani, Wimbush, Israelski, 2013; McCord, Liu & Singh, 2012).

In keeping with the principles of PHC and CBR, the functions of CHWs are country dependent, but may include conducting home visits, basic screening and identification of disease, data collection, education and counselling, and referrals for further care (Braun et al., 2013). By being involved in education and counselling, CHWs work closely with members of the communities and families, creating community empowerment and upliftment which are both underlying principles of the PHC and CBR approaches. By working closely with families, CHWs provide services as close to communities as possible, often in their homes. Community Health Workers can therefore be seen to adopt a FCC approach in the provision of their services.

To date, extensive research has been conducted in developing countries on the outcomes of community-based health programmes executed by CHWs. A systematic review of the literature base conducted by Rosenthal et al. (2010) showed that CHWs help to build individual and community capacity for health care through providing health information and empowerment and serve as community health educators and informal counsellors and community advocates. They go on to state that CHWs develop peer relationships with community members rather than client-professional relationships. It is emphasised that these relationships are the basis for improved health in communities rather than clinical expertise. They highlight the fact that communities are more likely to accept and use information when provided by someone with whom they can relate.

In addition, to the provision of information, Zulliger et al. (2014) described that CHWs can motivate individuals to initiate or re-establish a relationship with formal health care providers, emphasising the positive impact that CHWs are able to have on the health seeking behaviours of communities. It was also found that CHWs can advocate on behalf of patients at these very health care providers ensuring that the patient's needs are foremost in any decisions regarding their health care. Additionally, considering the financial constraints experienced by many low-income countries, the deployment of CHWs is seen as a necessary measure to improving health care outcomes for individuals as they are able to improve access to health care services at the appropriate level of care, which subsequently results in the efficient and effective provision of services (McCord et al., 2012). The success of CHW programs has pushed governments to invest in these programs to improve health care outcomes for communities (McCord et al., 2012; Naimoli, Frymus, Wuliji, Franco & Newsome, 2014).

Despite the successes of implementing alternative cadres of health care workers in resource low countries, reforms in improving accessibility to rehabilitative services, as opposed to primary health care services, have remained largely unmet (Gupta, Castillo-Laborde & Landry, 2011). It is for this reason important to consider the impact of using an alternative cadre of worker to improve access to health care and integration into society of persons with an existing health condition, disability or any rehabilitative needs in accordance with the vision of CBR.

In 2012 the Western Cape Department of Health (WCDoH) embarked on a pilot project which involved up-skilling CHWs to become Rehabilitation Care Worker (RCWs) for which the University of Cape Town (UCT) created a training program. A RCW is essentially an individual who has received basic training in the disciplines of Speech – Language Therapy; Audiology; Occupational Therapy and Physiotherapy and is able to provide services to individuals with health conditions or disabilities. These RCWs, like CHWs, have the potential to be catalysts for community development and may become key role players in the effective implementation of CBR strategies (Lorenzo et al., 2014; Mannan et al., 2012; Chappell & Johannsmeier, 2009). As RCWs are often from the very communities that they serve, they can act as mediators and often form the link between professional health care practitioners and members of the community. Rehabilitation Care Workers are

often able to transfer and contextualize information in a manner and language which is more relatable and understandable to community members because they come from the very communities they are servicing and are also familiar with the communities through their work as CHWs (De Kok & Louw, 2014).

The training of the RCWs involved in this study occurred from October 2012 – December 2013 and took place at the University of Western Cape Community Project building in Lenteguur, Mitchells Plain. During the one-year training program, RCWs received information and training on SLT; Audiology; Physiotherapy as well as Occupational Therapy. The RCW training program comprised of a theoretical as well as practical component which included clinical placement. Practice learning was facilitated at various community-based sites and facilities at district level in the Mitchell's Plain and Klipfontein area of Cape Town. The RCW curriculum included modules on: Health Wellness and Functional Abilities; Promoting Healthy Lifestyles; Inclusive Development and Agency; Disability Information, Management and Communication Systems and Work Integrated Practice Learning. The SLT component of the RCW training program comprised of an adult and paediatric module. Both modules focused on providing theoretical and practical training on communication development and feeding and swallowing difficulties. It also focused on an introduction to communication development and swallowing difficulties with regard to assessment, diagnosis and management. During training, the distinction between the roles of the SLT and RCW during assessment and management was discussed (C, Samuels, personal communication, 5 March 2018).

Due to the relative infancy of the RCW program, little research is available which focusses on facilitators and barriers for RCWs. The community health care worker "logic model" created by Naimoli et al, (2014) explores the factors which contribute to a successful CHW program. Naimoli et al. (2014) suggest that there is a strong interplay between the intrinsic motivators of community health care workers and various community and system factors. Exploration and consideration of these factors are important as they may provide insight into the effect of similar factors on other alternative cadre community programs. In a study by Campbell, McAllister and Eley. (2012) which explored the influence of motivation on the retention of rehabilitation and allied health professionals, it was identified that motivation and the sense of doing an important job has a significant impact on job satisfaction,

encouraging these individuals to remain in their respective fields of service. Safety in the work place has also been highlighted as a significant indicator of job satisfaction in a study conducted by Ojakaa, Olango and Jarvis (2014) which looked at job retention trends in community health care workers in Kenya. Community health assistants in Zambia reported similar findings in a study conducted by Zulu, Kinsman, Michelo & Hurtig, (2014). These community health assistants reported during interviews that passion and exacting visible change in their communities is what keeps them motivated despite facing workplace challenges.

At the time of this literature review, however, only three studies involved community-based *rehabilitation workers* as participants. Details of these studies are presented in the table below:

Table 1: Summary of research related to the current study

Author:	Date of publication:	Country:	Participants:	Aim:	Methodology:
Petrack, M., Schangwa, K., Pickford, K., Collinson, M.	2002	South Africa	Community Rehabilitation Workers	To understand how CRWs see their role, successes, supervision support received, problems encountered and possible solutions	Survey methodology
Rule, S	2013	South Africa	Community Rehabilitation Facilitators	To explore the training of mid-level CBR workers in South Africa, with a specific focus on the ability to address the oppression and empowerment of persons with disabilities	Action research: interviews and focus groups
Clarke, G.	2015	South Africa	Rehabilitation Care Workers (RCWs)	To describe the outcomes of the pilot Higher Certificate in Disability Practice (Rehabilitation Care and Support) Course, from the perspective of new graduates.	Focus groups

The focus of two of the three studies evaluates and reflects on aspects of training that the participants received (Clarke, 2015; Petrick, Schangwa, Pickford & Collinson, 2002). The third study (Rule, 2013) uses action research to explore the ability of CRF to address issues relevant to people with disabilities and consequently suggest adaptations to the CRF training program. The study by Petrick, Schangwa, Pickford & Collinson (2002) reported that community rehabilitation workers (CRWS) had significant impact on communities' perception of persons with disabilities, as they often formed the link between these individuals and the community structures which exist. They report better integration of these individuals from with disabilities into their communities when CRWS are present. Clarke (2015) also reported that RCWs are instrumental vehicles for improving access to health care as RCWs are not only agents for change in the communities where they work, but that they form an important aspect of interdisciplinary work. He states that the RCW program itself has been a catalyst for a positive personal change within the RCWs themselves. While these studies have highlighted the positive impact that these individuals can have on the health care system, these three studies also emphasised aspects to these programs which need to be addressed in order to provide an effective community-based service. Petrick et al. (2002) highlighted the need for regular supervision, support and training to ensure that their skills remain relevant to the communities they service and to ensure that they remain motivated in their work.

In light of the vast benefits seen to employing task-shifting to mid-level rehabilitation workers, the study by Munga et al. (2012) highlights the importance of ensuring that task-shifting does not result in inferior care and that this should be ensured by regular training and supervision programmes. Furthermore, the study by Dambisya & Matinhure (2012) explored the policy and programmatic implications of task shifting, highlighting the fact that often the mid-level workers themselves had misconceptions of what task-shifting entailed, including professionals not taking responsibility for their tasks and passing them along. Regular monitoring systems and effective communication channels are necessary to ensure that such misconceptions are clarified. The study by Rule (2013) which looked at the training program of Community Rehabilitation Facilitators (CRFs) adds that the training program needed adaptations to provide students with the necessary theoretical knowledge to ensure that they were adequately skilled to carry-out their duties. Rule (2013) added that there was significant change in the students' awareness of the oppression

experienced by individuals with disability following adaptations to the training program, and that their collaboration with patients subsequently improved. Challenges were also reported by the participants. Petrick et al. (2002) highlight that CRWs routinely complete a large variety of tasks such as health promotion activities, individual and group intervention as well as home visits, and spend considerable time walking between patients to complete these home visits. Additionally, Petrick et al. (2002) identified that while CRWs reported feeling valued and supported by the communities that they provide services to, they experienced a lack of appreciation and value by the Department of Health. To ensure the successful and sustainable implementation of RCW programs it is important to explore the factors which facilitate and hinder the provision of rehabilitation services in the community. There is a need for more empirical evidence to document the facilitators and barriers experienced by community-based rehabilitation workers.

2.7. Summary

This chapter explored some of the underlying political injustices which have impacted on the current public health care system of South Africa and have led to the health disparities experienced by most citizens. It then explored key strategies employed by National Government to overcome the challenges that many South Africans face daily in accessing adequate and appropriate health care. The value of training and employing alternative cadre health care workers to assist in achieving UHC was explored, with particular focus on CHWs and the potential of RCWs to form an integral part of this alternative cadre.

Chapter 3

Methodology

3.1. Introduction

This chapter details the rationale for the chosen research methodology and sampling method used in participant selection and provides a description of the participants consenting to participate in the research. The researcher describes the practices followed in gathering, processing and analysing data, as well as the strategies used to ensure the trustworthiness of the data. Lastly, the researcher outlines how the ethical principles stipulated in the Declaration of Helsinki were upheld.

3.2. Aim of the study

The aim of the study was as follows:

To explore the perceptions of Rehabilitation Care Workers (RCWs) located in the Mitchells Plain /Klipfontein sub-district, regarding the facilitators and barriers to providing Speech-Language Therapy (SLT) related activities in their work context.

3.3. Position of the researcher

The researcher is a Speech-Language Therapist working at a paediatric Intermediate Care facility within the Mitchells Plain/Klipfontein area and works with RCWs daily. She has also been involved in training programs for RCWs working within this region. In addition, her place of employment is used as a clinical placement site for RCWs during their training program. Due to the close working relationship between the researcher and RCWs, it was imperative that trustworthiness be upheld. Details relating to how trustworthiness was ensured, is discussed further along in this chapter. The researcher works closely with RCWs and during the management and planning of RCW activities she realized the need for a stronger literature base which could guide the supervision and mentoring process of health care professionals who work with this group of health care worker. Specifically, she realised that very little is known about the challenges this group

face as well as factors which motivate RCWs. Consequently, she embarked on this research study.

3.4. Research design

A descriptive exploratory qualitative approach was selected, as the aim of the study was to describe and explore factors influencing RCWs provision of services as expressed by RCWs themselves (Cresswell, 2003). This design was used as it allowed the researcher to explore a particular topic within its context (Creswell, 2003). It allowed the researcher to explore the role of RCWs within the communities where they work, as well as the facilitators and challenges they experience from their perspective.

Ontology is concerned with questions such as “what kind of world we are investigating?”, “what the nature of existence is?”, and “what the structure of reality is?” (Crotty, 2003). The researcher employed an ontological philosophical assumption in this research study as the primary intent was to explore the nature of reality for RCWs as well as to attempt to describe key characteristics of this reality (Cresswell, 2013). The researcher employed this approach as it was recognised that RCWs may have different perspectives or realities regarding the research question explored compared to other stakeholders such as professionals and those providing the RCW training. The researcher used quotes from the RCWs themselves to better understand these realities (Cresswell, 2003). To support the ontological assumption, the social constructivist paradigm was used.

Social constructivism or interpretivism as a paradigm involves research participants developing subjective meanings of their experiences (Cresswell, 2013). In this case, through their work and experiences RCWs have developed their own feelings and perspectives about their delivery of Speech- Language Therapy (SLT) related activities. These meanings are often varied and multiple, and may have been influenced by interactions with others, as well as through historical and cultural factors (Cresswell, 2013). In this paradigm, the researcher inductively develops a pattern of meaning and relies on participant views of the situation being explored (Creswell, 2013). The questions proposed to participants were therefore broad and

open-ended allowing participants to construct the meaning of the situation (Creswell, 2013).

3.5. Sampling

3.5.1. Selection criteria

The only inclusion criterion for the participation in this study was that the RCWs were employed by the WCDoH and working within the Mitchells Plain/Klipfontein sub-district. These individuals have been employed as RCWs within the sub-structure for 2 years at the time of the study. These RCWs were the first cohort employed within this substructure.

3.5.2. Sampling frame and method

Terre Blanche, Durrheim & Painter (2006) define a sampling frame as everybody in a specific population. All eighteen RCWs employed by the Western Cape Department of Health (WCDoH) within the Mitchells Plain/Klipfontein Sub-district were used as the sampling frame. Purposive sampling was used to select participants to approach for consent to participate in the study as the aim of the study was to represent the perceptions of a specific population (Neuman, 2006).

3.5.3. Participant recruitment

Rehabilitation Care Workers were recruited to participate in this study in an existing monthly face-to-face RCW meeting held at the Lentegeur sub-structure facility. During this meeting, the RCWs were informed of the details of the study and provided written consent at this point (appendix A). The RCWs were informed that confidentiality between group members could not be guaranteed due to the nature of focus groups, but that the researcher would implement measures to ensure that no identifying information would be reported during the data analysis phase of the research study. Furthermore, the RCWs were informed that there would be no direct benefits to those choosing to participate, but that the outcomes of the study may be used to make adaptations to the current training program and supervisors may use the results to improve the supervision and mentoring of existing and future RCWs. The researcher emphasised that participation would be voluntary and that there would be no consequence for choosing not to participate.

3.5.4. Sample size

Of a total of eighteen RCWs in the sampling frame, one RCW was on maternity leave and a further three were absent on the day of recruitment. This resulted in fourteen signed consent forms obtained. On the days of the focus groups, one of the participants was absent resulting in a total of thirteen participants.

3.5.5. Participant demographics

The thirteen participants, all worked as Home-Based Carers prior to becoming RCWs. Four participants were currently employed within the Intermediate Health Care sector at Sarah Fox Children's Convalescent Hospital and the other nine participants were employed in the Primary Health Care (PHC) sector. The number of participants according to age brackets are illustrated below:

Table 2: Participant ages

Below 35 years	35 – 40 years	41-50 years	51 – 65 years
1	4	6	2

All the RCW were bi or multi-lingual with the majority speaking Afrikaans and English (n = 5) or IsiXhosa and English (n = 8).

3.6. Data collection procedures, materials and research personnel

Focus group research methodology was chosen as the means of data collection. Focus group methodology has gained popularity as a means of gathering insights into a range of health service issues and is particularly useful in an area where little previous research has been undertaken (Willis, Green, Daly, Williamson & Bandyopadhyay, 2009). As the RCW field is, to some degree, still in its infancy, and very little research has focused on exploring this new field of health care, the focus group methodology was chosen as a method of data collection. Focus group methodology allows a group of people with similar characteristics (RCWs) to share their opinions and feelings in a non-threatening, conversation-enhancing atmosphere that promotes self-disclosure (Krueger & Casey, 2009). According to Willis et al. (2009) focus groups lend themselves to situations or settings where sociability is

important to the research problem such as, when analysing community development programs, or sometimes when needing to access groups who may otherwise not participate in research. In addition, Willis et al. (2009) state that the data gathered from a focus group interaction provides data which is far richer than data obtained from one on one interactions. The use of focus groups offered the researcher an opportunity to not only understand the RCWs views, but also to gauge the strength of the attitudes, beliefs and perceptions held, as well as the factors that influence these particular perspectives (Willis et al., 2009).

3.6.1. Ethics approval, obtaining permission and researcher training

The researcher obtained ethics approval from the University of Cape Town Faculty of Health Sciences Human Research Ethics Committee for ethics approval (see appendix B) which was obtained in April 2016 with the reference number 095/2016. The researcher then applied for permission to conduct the research study from the WCDoH Strategy and Health Support Department, which was granted by Dr. Hawkridge who is the Director of the Health Impact Assessment Department (see appendix C). The RCWs were working in the Mitchells Plain area servicing Mitchells Plain Community Health Centre (CHC) and hence approval for research relating to this site was requested. The next step involved the researcher contacting the Rehabilitation Co-Ordinator for the Mitchells Plain/Klipfontein area to request permission to conduct the study and approval to continue with the research process was subsequently obtained (see appendix D).

Before recruiting participants for the study, the researcher equipped herself with the skills necessary to facilitate a focus group. A tailor-made training program consisting of both a theoretical and a skills component was completed. To ensure the researcher had adequate theoretical background to conduct a focus group, a 5-part webinar series which was designed to provide information on how to conduct and analyse focus group research (available at <http://cssl.osu.edu/training-webinars/>) was completed. Once this was complete, the researcher recruited fellow SLTs and Audiologists working within the Mitchells Plain/Klipfontein sub-district to participate in a pilot focus group which aimed to explore the facilitators and barriers that they experience in providing services at a Primary Health Care level, allowing the

researcher the opportunity to develop her skill and confidence in conducting a focus group.

The pilot focus group was conducted in the same venue earmarked for the focus groups with RCWs, this was done to ensure that the researcher was familiar with the logistical aspects of the venue and allowed for the researcher to determine whether the room would be best suited for the focus group discussions by looking at the natural light and flow of the venue. It also allowed the researcher to identify the ideal set up of the room for the strategic placement of all recording equipment. The researcher employed the assistance of a skilled researcher to observe the focus group and after the focus group both researchers reflected on the process and highlighted any problem areas which could be improved upon before the data collection occurred with the RCWs. These suggestions were noted and strategies to resolve them were agreed upon, such as using non-verbal communication such as nodding to show acknowledgment and affirmation the participants opinions.

3.6.2. Materials and equipment

The researcher in consultation with her research supervisors and relevant literature created a tailor-made interview guide (Appendix E) which consisted of a set of key questions, as well as several probing questions for each key question. The 5 categories of questions suggested by Krueger and Casey (2009) namely: opening question; introductory question; transition question; key questions and ending questions were used as a guide. To ensure the credibility of the interview guide, the researcher was guided by the aim of the research study and due to the research base relating to enabling optimal work environments for rehabilitation workers or community health care workers is limited, literature relating to job satisfaction was consulted. For this study, Warr's Vitamin Model was used to design the open-ended questions used during the focus group. Warr's Vitamin Model suggests that mental health is affected by environmental and psychological factors and highlights areas that influence job satisfaction and the performance levels of healthcare employees (De Jonge & Schaufeli, 1998). This model identifies 9 areas of importance, namely: job autonomy, job demands, social support, skill utilization, skill variety, task feedback, salary, safety and task significance (De Jonge & Schaufeli, 1998).

The researcher used a Dictaphone to record the verbal interactions during the focus groups, as well as a video recorder to capture any non-verbal nuances displayed by participants. Audio-visual data enhances the accuracy of data analysed (Cresswell, 2003). Use of an audio recorder allowed the researcher to keep a detailed record of the focus group interview without being distracted by detailed note-taking (Terre Blanche et al., 2006). Furthermore, the use of recording devices showed participants that the researcher valued the importance of what their opinions (Terre Blanche et al., 2006). The researcher placed the Dictaphone in the middle of the focus group area, on a table at approximately the same height as the chairs to ensure that recordings were clear.

3.6.3. Personnel

The researcher employed the help of a research assistant who is currently completing her PhD in Speech-Language Pathology and had experience in facilitating focus group interactions. In preparation for the focus groups, the researcher and research assistant met prior to the first focus group date. Here the research assistant was briefed about the study, its aims and its objectives. She was also informed about the participants, their training backgrounds, age and language. The researcher stipulated the roles and responsibilities of the research assistant both during the interactions and after the focus group completion. The research assistant was tasked with taking notes, managing the recording devices, observing the subtle non-verbal cues made by participants and noting any other group dynamics of interest.

3.6.4. Data collection procedures

Two focus groups were held on 27th and 30th of August 2016 with six and seven participants respectively, at the University of the Western Cape Rehabilitation Project site on the Lentegeur Hospital premises in Mitchells Plain. Fourteen signed consent forms were obtained during recruitment process; however, one RCW was absent on the 27th of August and therefore the focus group has one less member than originally planned. This location was selected as it is the same venue where the RCWs have their monthly meetings and was the place where their training program was conducted, as the location was conveniently accessible for all and familiar and consequently non-threatening (Stewart, Shamdasani & Rook, 2007). The researcher

and a research assistant were present at the focus groups together with the participants. Participants were encouraged to arrive fifteen minutes prior to the start of the focus groups, and light refreshments were provided during this time to allow for the participants to familiarize themselves with the setting and the other participants. Audio and visual recordings were used, and notes were taken by both the researcher and research assistant during the focus group interaction, to capture dynamics such as multiple participants agreeing to particular statements and the general mood of participants (Cresswell, 2013).

Seating was arranged in a closed circle with the audio recorder in the centre of the circle and the video recorder positioned on the outside of the circle strategically placed as to not be intimidating, but still able to capture all participants and the researcher. This was chosen to create a comfortable, non-threatening setting (Krueger & Casey, 2009). Each participant received a name tag before taking their seats, the researcher and assistant also received name tags. The research assistant assigned each participant a number in the order of the way they were seated. This enabled the researcher to easily refer to particular participants when making her notes and ensured that no identifying data was captured during the focus group process.

The researcher opened the discussion with an introduction which emphasized the importance of confidentiality. The introduction also highlighted several logistical considerations which needed to be followed e.g. switching cellular phones off. The researcher then discussed the aim of the study and why the discussion was being recorded. The focus group discussions were held in English, as all participants could converse in this language, however participants were encouraged to stop the researcher at any time if she was speaking too fast or if they needed anything repeated. The researcher then used the interview guide to commence the discussion. The two focus groups were held for 1 hour 10 minutes and 1 hour 15 minutes respectively.

During the focus groups the researcher facilitated the flow of discussion by prompting overtly quiet participants to comment in response to the questions posed. The focus group discussions were concluded by the researcher, who summarised the information shared by the participants and created an opportunity for the

participants to confirm that her summary was accurate. Participants were thanked for their contributions and time and the researcher communicated that they would be contacted again once the data had been transcribed for an individual opportunity to comment on the accuracy of the transcription and were told that they would also receive a written document which highlights the key findings of the study.

3.7. Data management

Data from both the video recorder and Dictaphone were transferred and downloaded onto the researcher's laptop which was password protected and only the researcher had the password. Once the recording was transferred to the researcher's laptop, it was immediately deleted from the recording device. This was done to ensure confidentiality of the data by limiting the number of people who had access to the raw data. The researcher contacted the University of Cape Town (UCT) Clinical Research Centre for accredited transcription services, where the researcher was encouraged to contact On Time Transcribers. The audio recordings obtained from the focus groups were then submitted to the transcription service and returned to the researcher after three weeks. The researcher then checked the transcription of each of the focus groups once it had been received from the transcription service, to ensure that the transcription was accurate.

3.8. Data Analysis and Interpretation

Once the data was adequately transcribed, the researcher provided each RCW who participated in the focus groups with the opportunity to read through the transcription and confirm its accuracy (Babbie & Mouton, 2004). Participants were invited to provide feedback on a feedback form (Appendix F) to indicate that they were satisfied with the accuracy of the transcription or to provide amendments to the transcript to improve its accuracy. Participants were able to take the transcriptions home and were given a period of two weeks in which to read and request edits to the transcription. Once all forms were completed and returned, thematic analysis commenced. All participants returned the forms stating that they were satisfied with the accuracy of the transcription. Thematic analysis then commenced.

The process of thematic analysis employed by the researcher with the assistance of her research supervisor, involved preparing and organizing the data, reducing the data into themes through open coding (reducing the data into meaningful segments and assigning names for each segment), condensing the codes into broader themes and finally representing the data in text, figures, and/or tables (Creswell, 2013; Neuman, 2006; Terre Blanche et al., 2006). Once this process was complete, the researcher formulated a coding rubric with the assistance of her supervisor and co-supervisor (Appendix G). The data obtained from focus group two was then segmented into meaningful units and placed in the corresponding code based on the coding rubric. Axial coding was employed at this stage as the researcher reviewed and examined the initial codes created (Neuman, 2006). If the meaningful unit did not fit into any of the existing codes, the coding rubric was edited in such a way that allowed all meaningful units to be placed within an appropriate code. Once the data from both focus groups had been grouped into the appropriate codes the existing codes were then grouped into over-arching themes. The researcher's co-supervisor who was not involved in the original coding of the data (but did assist with the development of the coding rubric) was then enlisted as an additional coder to ascertain whether the codes were appropriately formed into themes. A process of consensus was employed where disagreements existed between the student and the supervisors. These themes will be discussed in the results chapter of the thesis.

3.9. Research Rigour (Trustworthiness)

The criteria developed by Lincoln & Guba (1985) to ensure trustworthiness were used to guide this research process. Ensuring trustworthiness involved employing measures which ensured that results could be trusted and that findings are worth paying attention to (Lincoln & Guba, 1985). Trustworthiness encompasses four components, namely: credibility, transferability, dependability and confirmability (Thomas & Magilvy, 2011). It is important to remember that as purposive sampling was used, only the opinions and feelings of RCWs working within the Mitchells Plain/Klipfontein sub-structure were captured and consequently the themes produced from the data set is not necessarily indicative of the feelings of RCWs working in other sub-structures of the Western Cape.

3.9.1. Credibility

Credibility, as described by Cope (2014), involves the presence of generalized feelings and experiences amongst participants. Ensuring credibility allows the researcher to identify and describe instances where participants recognize and share views and opinions which ultimately contributes to the accurate representation of data by the researcher. Credibility may be achieved through employing measures such as member-checking; triangulation and debriefing (Cope, 2014). The primary strategy used by the researcher to ensure credibility was member-checking. Once the data was transcribed verbatim, the RCWs were given a copy of the final transcription to review and to determine whether this was an accurate reflection of their words and feelings. In addition to this the strategies of debriefing and investigator triangulation were also employed. To debrief, the student consulted both the research assistant and research supervisor to identify and highlight any ideas or notions which may have influenced the data analysis process. Investigator triangulation (Carter, Bryant-Lukosius, DiCenso, Blythe & Neville, 2014) was ensured by the researcher employing the help of a research assistant in the gathering of data and also by involving three researchers during the formation of the codes and themes from the data.

3.9.2. Transferability

Transferability describes the extent to which results can be applied in similar contexts (Cope, 2014). The questions used in the focus groups were standardised across both focus groups. As mentioned above, the results obtained from the study may not be representative of the feelings and opinions of all RCWs however the research process is described in sufficient detail to allow the study to be replicated in other settings.

3.9.3. Confirmability

The researcher aimed to achieve confirmability by using quotes from participants to depict a true representation of their feelings and viewpoints. In addition, following each focus group the researcher noted any feelings of bias, personal feelings or insights which may have had an influence on the data analysis process (Thomas & Magilvy, 2011). Measures of bracketing (memoing, reflective journal, bracketing interviews and peer debriefing) were employed to ensure that findings were both accurate and objective as the researcher works closely with RCWs on a daily basis

(Terre Blanche et al., 2006). The researcher used memos which allowed her to examine and reflect on her engagement with the data, allowing her to detect any areas where preconceived ideas or feelings may be having an influence (Tufford & Newman, 2010). The researcher also conducted bracketing interviews and peer briefing with the research assistant as well as her research supervisor (Tufford & Newman, 2010; Creswell, 2003). This strategy was employed to highlight any biases and pre-conceived notions. Employing these strategies enriched the researcher's engagement with the data and allowed her to remain reflective throughout the research process.

3.10. Ethical Considerations

Ethical approval from The University of Cape Town Faculty of Health Sciences Human Research Ethics Committee was obtained in April 2016 based on ethical principles set out in the Declaration of Helsinki (World Medical Association, 2013), as discussed below.

3.10.1. Confidentiality

The researcher emphasized the need for confidentiality between participants in the informed consent letter provided to participants, as well as during and after the focus group sessions. The researcher also notified participants that confidentiality between participants could not be guaranteed during the consent procedure. All identifying information of participants was protected by assigning a number to each participant during focus groups. Furthermore, audio and video recorded data was stored on a password-protected laptop accessible only to the researcher. After publication of the study, the data will be destroyed by removing the focus group videos and audio recordings from the researcher's password protected laptop and all transcriptions will be shredded.

3.10.2. Autonomy

The researcher explained the project in sufficient detail for the RCWs to make an informed choice to either participate in the research study or to decline participation. Participants were informed that they have the right to withdraw from the study at any time without experiencing any negative consequences from their employers (Terre Blanche et al., 2006).

3.10.3. Beneficence

The RCWs were informed that there would be no direct benefit to them by participating in the research study. A potential benefit of participating in the study is that RCWs may feel empowered knowing that they may be contributing to future adaptations to the RCW training program. This indirect benefit was also discussed with them.

3.10.4. Non-maleficence

The research study was deemed to be of minimal risk to participants. Participants were informed that confidentiality could not be guaranteed as other members of the group might disclose information shared within the setting, but that the researcher would not use any identifying information in the analysis or writing of the dissertation. The researcher emphasized the importance of and need for respect of each other's opinions as well the confidentiality of the information shared within the sessions. The focus group dynamic could potentially have elicited sensitive information from participants. No feelings of vulnerability or distress were reported to the researcher during or after the focus group sessions.

3.10.5. Justice

All eligible participants were invited to participate in the study ensuring fair and equal inclusion of all RCWs in the Mitchells Plain/Klipfontein sub-district. All participants were provided with the transcriptions of the data that they provided and given the opportunity to clarify or elaborate on any points in the transcript. Furthermore, outcomes of the study will be shared with all participants, the Department of Disability Studies at the University of Cape Town as well as the Rehabilitation Coordinator for the sub-district.

3.11. Summary

This chapter has elaborated on the choice of research methodology, as well as its advantages and challenges, as well as the theoretical assumptions underpinning this choice. It details the processes followed in gathering, processing and analysing the data in sufficient detail to allow the study to be replicated. Furthermore, this chapter

provides information as to how research rigour and ethical principles were upheld. The chapter which follows will detail the main findings which emerged from the data.

Chapter 4

Results

4.1. Introduction

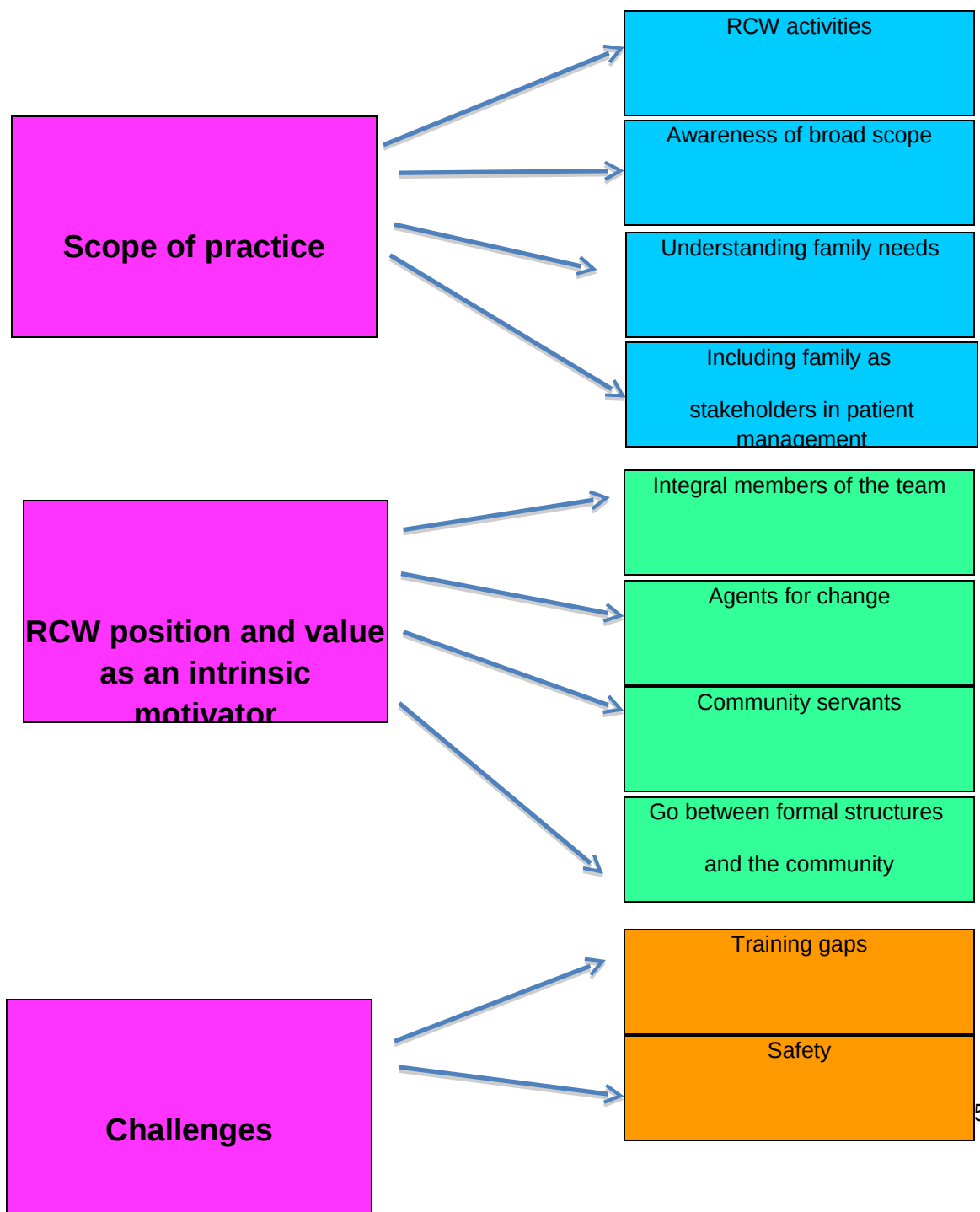
The findings of the research study are represented through a rich description of the perceptions expressed by participants and are visually represented in diagrammatic form. These perceptions will be explored through three overarching themes which will include the codes which substantiate them, as well as direct quotes from the participants to support these themes pertaining to these themes and sub-themes. It is important to note that as all the participants were bilingual, culturally appropriate interjections (such as “ja”, “ne”, “mos”, “ow”) have been retained in the excerpts.

4.2. Plot - Vital role players

A plot synthesizes themes into an encapsulating message (Polkinghorne, 2005). In this study, the plot which best articulates the message from the participants is that they are vital role players in the professional teams they form part of, as well as in the communities which they serve. Participants decisively expressed their perceived value as providing a scarce service to many disadvantaged in the communities they serve. They also elaborated on the fact that their work often requires them to go beyond their scope of professional activities; as they regularly become advocates for their patients in many other spheres of the patient's life (such as education and employment). In viewing themselves as such a vital asset to the health care system,

the RCWs also expressed discontent at the lack of recognition they receive, not from their patients, but rather from their supervisors, managers, and from the Western Cape Department of Health (WCDoH). The plot captures the participants' firm standpoint that the work they do is of utmost importance and depicts that they have forged a niche for themselves in their work communities.

During the data management and analysis process three primary themes emerged, namely: *scope of practice*, *Rehabilitation Care Worker (RCW) position and value as an intrinsic motivator* and finally, *challenges*, each with sub- themes which are depicted in Figure one.



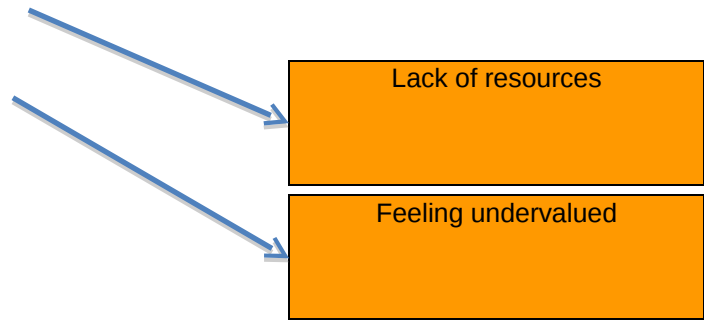


Figure 1 – Overarching themes and related sub-themes

4.3. Theme one: Scope of practice

Theme one explores the extensive variety of tasks that RCWs complete; the supportive role they provide for their patients and their patients' families alike, as well as articulating their position within the multi-disciplinary therapy team. It is important to remember that RCWs implement tasks from all rehabilitation disciplines. It is also clear that many of the activities of RCW are underpinned by the principles of Family-Centred Care. Family-Centred Care relies on the analysis of individual family dynamics and looks at the influence of family motivators and stressors on health care while aiming to counteract these stressors through education and guidance (Coyne, 2013). But providing the necessary support and guidance families are empowered to become active members of the therapy team. Furthermore, adopting a FCC approach allows the RCWs to transfer the skills and knowledge that they have acquired to the family of their patients. Theme one is comprised of four sub-themes namely: *"RCW activities"*; *"awareness of broad scope"*; *"understanding family needs"*; and finally *including family as stakeholders in patient management"*. These sub-themes will now be discussed in more detail.

4.3.1. *RCW activities*: The researcher wanted to gain insight into the daily activities of RCWs to better understand their roles within a therapy team. It was noted that tasks performed by the RCWs are setting dependent, as tasks described by participants who are community based differed to some degree to tasks reported by those who are facility based.

"Because I was interested to help people in the community and to do active or passive movement to do activity of daily lives and to facilitate how to dress and cleanse himself and by demonstrating and also to help with the family for grooming, eating independently; how to transfer from bed to chair from chair to bed and from chair to the toilet and also how to deal with speech clients in the community and also do the community resource file the support groups that are around so that I can refer the patient and also make the patient stronger, and also to empower the patient by spiritual if he or she believe by praying and also reading the Bible and also to form the small support group to the patient nearby by asking permission from the patient and from the family, And also to do audio in the clinic so to test the hearing loss of MDR TB and to do the stats and also work as a team".

(Focus group one participant one)

From this extract, one can see the broad range of activities that RCWs are often involved in. The participant who provided this quote also made it clear that working as a team is part of the day to day activities of a RCW, emphasising that team work is deeply rooted in their way of working. This participant who works in a community setting also highlighted support groups for both patients and families as one of the regular activities which she engages in, showing a sense of understanding that community awareness and empowerment is integral when working in a community setting.

“There are Sarah Fox we work with the children who is develop, who I can’t get the word on my tongue, developmental children... who is at least you must know at what age the children is and at what age the children must be like maybe for a month the children’s head mustn’t lag, and what age they must crawl, or sit we working on that to strengthen the muscle to work on the muscle tones and to achieve their goals for their age range. And we do also the audio to the babies that is two days a week Tuesdays and Thursdays and we help mos the speech therapist because the OT and the Speech therapist is working with us”.

(Focus group one
participant two)

Even though the participant who provided the second excerpt is based in a facility and the activities are geared toward the paediatric population, one can see that team work between the RCW and other health care professionals is also fostered in this environment. However, it is clear that RCW are involved in carrying out tasks from a number of therapeutic disciplines, and that teamwork is integral to the way in which RCW work.

4.3.2. *Awareness of broad scope:* the RCWs expressed that their duties are broad and far-reaching. They explained that their duties often involve collaborating with

different disciplines, as well as combining different techniques and strategies from each discipline into one session. Throughout the discussions, RCWs spoke about the tasks they complete and the roles they fulfil. On one hand, some RCWs were somewhat proud of the fact that they can integrate so many different roles in their treatment of patients, however on the other hand, some RCWs communicated feeling overwhelmed by fulfilling too many roles and completing too many tasks. Gopalan, Mohanty and Das (2012) explain that feeling overburdened has a significant negative impact on job satisfaction as found in their study which looked at job satisfaction in community health workers in India.

"I think from my perspective; I won't say that it's something easy. Being a RCW is very challenginglike you know, we are a combination of 4 professions and to include that on a day to day basis, it's very hard..."

(Focus group one participant
four)

"....we do exercise, we do ADL, we also do the speech, we also do the counselling, we also do the refers. We also run the support group at different day, Tuesdays and also Thursdays. As proof of evidence we also have a time sheet where we put our client's initials"

(Focus group one participant one)

"Say like for instance I forgot about uhm of the speech probably then I would ask [name] can we be trained on this and she would provide training. She will say Okay I'm gonna come back, that is just to freshen up the mind because sometimes we forget because we do so much... you know we do so much, like different kinds of.... like say today I'm doing speech, tomorrow I'm doing audiology. This day I'm doing physio and ADLs and that day I did. So you tend to forget actually"

(Focus group one participant
five)

Here one can see the conflicting opinions expressed by participants. Rehabilitation Care Workers expressed that the broad range of activities they complete sometimes leaves them feeling stressed and overburdened. At times, it also makes it difficult for them to plan appropriately for a patient based on his/her needs, as they forget or are unsure of the ways to manage a particular problem.

4.3.3. *Understanding family needs:* Throughout the discussions, the RCWs made mention of the fact that their work with patients involves not only the patient themselves, but their families as well. Rehabilitation Care Workers expressed that understanding the dynamics and individual needs of each family is an important consideration when managing a patient. This acknowledgement of the vital role of family in the provision of patient care, and the subsequent importance of supporting the family to enable them to be actively involved speaks to RCWs holistic view of patient management and the integration of the Family-Centred Care (FCC) approach in the way they work. This holistic view of patient care contributes to the plot of RCWs being vital role players in the communities as they consciously attempt to understand and value the particular needs of each family and provide the necessary support.

“And the strength that I would say is the listening skills that I have, if you go into the house I have to ask them like how is [Name] doing? How did she interact? And I would like to listen, to hear what the mom or the grandmom has to say like from the beginning and that even though she was off the day, off the night or like they would say naughty, or terrible or things like that, but I would listen to what they say and how they feel as well. So, I would consider the family, how they feel about everything, take it into account, their stresses as well”.

(Focus group one participant five)

“Okay, we experience a lot in CBS (community-based services) that the families sometimes don't understand when the people have the stroke, so now we educate and we show for that and they can know the big support is coming from the family and the continuation of their treatment in homes is really important.

(Focus group one participant one)

4.3.4. *Including family as stakeholders in patient management*: When interrogating the theme of scope of practice, it was evident that RCWs make a conscious effort to include family members of their patients in treatment. Subsequently, the sub-theme of *including family as stakeholders in patient management* was identified. Here, RCWs were clear that families play an important role in patient care and that their work would not be as effective without the assistance of the family.

“... and support from the family, because if the family don’t understand, what are you doing there? “

(Focus group one participant three)

“ Ja, because sometimes we have to count on that family or that mother, or sometimes the father...”

(Focus group two participant one)

Rehabilitation Care Workers often rely on family members for the continuation of treatment in their absence, and to assist in motivating the patient during their rehabilitation. Consequently, RCW often mentioned patient education as a strategy they use to ensure that families can continue treatment between RCW visits. The above mentioned sub-theme was expressed by more than one participant and the same message was relayed from both focus groups. This solidifies the fact that family plays an important supportive role in the therapy team, is a thought which is shared by RCWs as a collective.

4.4. Theme two: RCW position and value as an intrinsic motivator

Theme two explores the pivotal role that RCWs play in their work environments. It details how their deep-rooted love for their communities have propelled them into this field. It also elaborates on how RCWs have become integral members of their therapy teams and how they use their love for their community, as well as their roles as “the voice of their patients” to advocate for their patients in all aspects of their lives, not only therapeutically. These intrinsic motivators of the position and value of

the RCW will be explored in four sub-themes namely: *“integral members of the team”*; *“agents for change”*; *“community servants”*; and finally *“go between formal structures and the community”*.

4.4.1. Integral members of the team: With this sub-theme, RCWs had differing opinions as to how they integrate into the therapy team. On one hand, some were clear that the rehabilitation professional needs to assess the patient and then formulate a plan which the RCWs would then be tasked with implementing, while on the other hand, others felt a bit unsure of this as in some cases they see the patient before the rehabilitation professional has had a chance to do so. Despite these differences, an underlying message of collaboration between rehabilitation professionals and RCWs was evident.

“I visit the client after the supervisor, because it’s a professional OT or speech go first and give me the goals that must I do for the patient. So I just do the plans for that patient, because I have a clue what must I do. Professionals do first”.

(Focus group one participant three)

“Ja, I would say that the biggest help would be from the speech therapist and the family as well because they have to work hand in hand, we all have to work together as a team , so if I don’t know what to do or what to say next, or my next move would be, then I would always ask my speech therapist please help me with this, I don’t know this and I don’t know that, or what can I do here, or what can I do? I don’t want to do my own thing and that’s why I’m going to ask you is it okay if I can go to the crèche and observe? So I need to always engage with her and with the family; so if we work as a team, then it’s great”.

(Focus group one participant five)

“For me, no support. Because yes [name] did give us speech training several times, but I report that I’m struggling with this

Autistic children [sic]. At least she must go reassess and see why I'm struggling. Go with me at least see what I'm struggling with. She didn't go so I end up not knowing what to do... don't know whether what I'm doing is right is wrong, I'm just doing my own things".

(Focus group two participant

two)

Through the above excerpts one can see the opposing thoughts. One participant is quite clear in her statement that "professionals do first" (excerpt one). There appears to be a somewhat reciprocal relationship between the therapist and RCW as communicated in excerpt two, whereas excerpt three alludes to the fact that sometimes this relationship is blurred and RCWs are left to treat patients' unsupervised and without the necessary guidance, which often leaves them feeling unsure about the treatment they are providing. Possible reasons for this trend will be discussed in the discussion chapter of this dissertation.

Another interesting comparison can be drawn between the relationships between RCWs and rehabilitation professionals who are facility-based versus those who are based in the community. This can be seen in the passages extracted below.

"To us at Sarah Fox we got the support because our supervisors, they give us training so that we must know about the speech, and when they assess they give us the recommendation and they are also able to, if we don't understand anything about speech, it's easy to meet them and then go and ask. Ja, so we've got the support. It's only you if you don't take part, but they give the support".

(Focus group two participant six)

"You know you can train me here when I get there you know I'm not a Speech Therapist mos I never learned a Speech Therapist now I'm alone there, and now [Name of client] do this, don't do it

again. “[Name of client] this” don’t do can’t talk, can’t do anything, just that he understand what you say but can’t do everything, this is the support that I need that I don’t get. If you refer a client to me, then I struggle, and I ask you, at least come with me to that house so that you can see, you reassess and then you are going to tell me when you do treatment there, then I’m going to watch you, then I will know if I must do this thing. So that you can tell me you must do this, you must that. I go there, and I do what I’m told, but it’s not helping and you expect improvement, there is no improvement sorry”

(Focus group two participant two)

There seems to be a striking difference in that RCWs who are facility-based feel more supported by their supervisors than those who are based in the community. This may be because there are few therapists in the Primary Health Care (PHC) sector and they are not always able to accompany RCWs to their patients. In contrast, RCWs who are facility-based have their supervisors in close proximity to them at all times, allowing RCWs to access to the skills and expertise of their supervisors more easily.

4.4.2. *Agent for change*: There was a strong sense of pride when RCWs were discussing the work they do. Every member of each group was able to mention at least one highlight they have experienced since becoming a RCW, and these experiences were often linked to feelings of gratification at seeing their patients do well.

“Ja you feel great when you achieve your goal on that person, like you want that person to do that thing like once that person is on the end of all your hard work and now the person is better.”

(Focus group one participant two)

“Ja, having worked here in the community ja, you see those problems ne, if maybe you see that ow, I did help there because you see the improvement it makes, you feel, it makes you feel ja more motivated”.

(Focus group two participant three)

RCWs identified a position of value and worth for themselves by seeing the impact that they can make in the lives of their patients. This sentiment again was shared by participants across both of the focus groups. The sense of being fulfilled when seeing improvement in their patients and their families is an inherent motivator for RCWs.

4.4.3. *Community servant*: Through the discussions, it was evident that RCWs value their communities. The thoughts expressed consistently lead back to the problems their communities face and how these communities need more investment from the National Government. Another perception which arose from discussion was the lack of education in communities regarding healthcare and health seeking behaviours, particularly around disability and the stigma surrounding this topic that still exists today.

“It was always about the community and to educate the community. You can’t stop educating because we were sent away to study, to educate us and that made us clever and it make us stronger and to believe what you achieve to become successful. And if you look in the community, the people we touch, it’s a success, and that’s for me is the highlight”

(Focus group one participant seven)

“The reason why I decided now to join the group of the rehab workers, before I was working as a CHW (Community Healthcare worker), so having working in community ne, I experience that there are many problems in as far as the health of the people in the community. So there were many cases of the rehab clients and I could see that ne it felt like nobody is taking care of them ne, like you’ll find that ne it’s difficult for them to even go to the clinic uh, some are staying alone, some uh the families don’t take care of them ne as they should be. Ja, that is make me want to join the rehab”.

(Focus group two participant three)

“....I’ve also worked very long for home based care and in our community there was a lot of people living with a disability and

some of them go through a lot of things, have family issues, like there's no support and they just keep them behind doors and withdraw them from other people, and I think there's a lot of stigma against people with disabilities. And like they need a lot of care and they need a lot of support from community and family".

(Focus group two participant one)

The deep understanding of community needs is clearly depicted in the above-mentioned excerpts. There is also a clear willingness to help those who are marginalised. These two thoughts were shared by several participants within each of the two focus groups solidifying its value as a sub-theme.

4.4.4. *Go between formal structures and the community:* Since RCWs are so deeply rooted in the communities where they work, they often go the "extra mile" to ensure their patients receive the best care and are functioning at their most optimal level. RCWs become advocates for their patients, accessing resources the patient may not have been aware of or known how to access.

"...I also had a male client way back, he was a coach of the rugby team and he was also working but he lost this job because of the stroke and [name] and myself we fought to get his job back, I had meetings at the workplace, got disability aid in, gave him exercises had him running upstairs and running around the race track, got him back into coaching, got his marriage back on track, got his job back supporting his kids..."

(Focus group one participant four)

"it broadened my knowledge and my skills as well because you go into a home and you have to go holistically and then you find out you're not working with one kind you're working with the whole household. So you try to figure out where you can help so you know you have to have like a community profile, so you know exactly where to go and you try and have interviews for the people that you need to go see to help the family itself, so whether it's like the ward council, whether it's like the police, whether it's like the doctor or the sister whatever the help they need or even the mental health sister..."

(Focus group 1 participant five)

With these two extracts one can see the extent that RCWs will go to, to assist their patients. Interestingly, all the passages for this sub-theme were from RCWs based at the PHC level. This may be since the RCWs who are facility-based do not often venture beyond the facility itself and subsequently do not have much involvement with the patients once they are discharged from the facility. All intervention at these facilities is on an in-patient basis.

4.5. Theme three: Challenges

Theme three explores challenges that RCWs encounter on a daily basis. These challenges include not only physical barriers but also challenges relating to resourcing and staff development as well as factors negatively affecting their motivation. This theme is comprised of 4 sub-themes namely: *“training gaps and supervision”*; *“safety”*; *“lack of resources”* and *“feeling undervalued”*.

4.5.1. Training gaps and supervision: Throughout the discussions in both focus groups, participants emphasised a lack of exposure to Speech-Language Therapy (SLT) activities during their training program. When enquiring about the activities RCW execute, activities related to Physiotherapy and Occupational Therapy were frequently listed, while activities related to SLT were not mentioned as frequently. When asked specifically to reflect on their training many of the participants identified the need for further exposure and training in SLT related activities. In addition, because Speech-Language Therapy was highlighted by the RCW as an area for improvement in the RCW training program, RCW pointed out that this gap required them to request more hands-on supervision from the supervisory rehabilitation professionals when they were employed.

“My experience as a rehab care worker, is that more knowledge, I have knowledge. Then practical there’s sometimes I get stuck. Let’s say for speech, there are those like Autistic children which I get stuck because the autistic children maybe they some of them don’t have speech anymore some of them they have speech, but they don’t concentrate. You plan to do this, and they don’t concentrate... they do other thing so I get stuck don’t know what to do. That would make me struggle. In the case of a treatment plan

for maybe CVA or amputation I think I'm doing well because they improving. And the children that are flaccid, I have one there at Crossroads, she's now like can sit and maybe like five to ten seconds like she's improving and that makes me feel well and to see that do something. Some patient they didn't have functionality but now you can see that maybe the client can transfer from bed to chair and back to bed and transfer wheelchair to toilet seat and back, so I feel good".

(Focus group two

participant two)

"...I think most of our problem is that we didn't get information about the speech therapy [in] our training, we only got speech here, so to us it was new things. I would like to learn and learn, and as we get the cases it's when you learn. Oh, I have this case now and you go to your OT or Speech Therapist.... I have come across this particular problems [sic] so what do I do? I go about it then they will explained [sic] to you and then we also have like the [unclear] where you raise uh your concerns about the speech so we need that ongoing like training on speech".

(Focus group two

participant three)

"To my side I thought we need more to the speech, because the patient take more time to be able to see the improvement of the child, so it needs more dedication, to be more patient to that, so to me speech is very difficult".

(Focus group two

participant six)

Training in SLT-related activities was the predominant area where RCWs felt they needed more learning opportunities, not only during their formal teaching but also regular refresher training now that they are working in the field. Rehabilitation Care Workers also identified more specific training needs related to their work experience with certain types of disabilities, particularly, Autism Spectrum Disorder (ASD).

4.5.2. *Safety*: Rehabilitation care workers across both settings and groups indicated that their safety is of primary concern to them. Although the RCWs came from two different working environments, it was clear that safety concerns were shared by both groups although these concerns were of a different nature.

The RCWs based in PHC emphasised that their communities are unsafe and in some instances they indicated that they fear for their lives. The Mitchell's Plain area has a high rate of gang-related violence (Luthango, 2016) and often the RCWs working within this area come face to face with this danger. Rehabilitation Care Workers conduct home visits as part of their duties and as they are not provided with transport, consequently they are required to either use public transport or walk to their patients. The RCWs are therefore more vulnerable during these instances of violence than they would be if they had their own means of transport.

"So there's a shooting; there was a shooting taking place over the weekend. So now we already know, we are ready, although we don't stay in that certain area, but we know because word gets out there was 2 or 4 who was being murdered or shot like and that is the area we are working in. So we have to be careful how we walk; because now it comes any time it can be that time again that it starts..."

(Focus group one

participant seven)

"...in some areas it's not safe, but you go into a house where it's drug related. There's times that you can go to that client and the client will tell you they are shooting, you mustn't worry to perform treatment, then she will tell you, you must come back another time, so there's a lot of violence in our community".

(Focus group two participant one)

"By us in Tafelsig, if they're going to shoot then, they have a great respect for the home-based carers and for us, because they say if

they land in the hospital it's the rehab people and the home-based carers that come and help them to get better. If they're going to start shooting, they will tell you "Sister, maak jou snaaks, we gonna shoot now". And they wait until, but sometime [sic] they can't even warn you. We in, when you walk you can hear the gunshots".*

(Focus group one participant seven)

- *"Maak jou snaaks" loosely translates to "make yourself scarce"*

In contrast, the RCWs who are facility - based communicated safety concerns of a different nature. Physical safety was not prioritized by this group of RCWs, but health safety was. These occupational health concerns included poor infection control, poor management of biohazardous material and lack of health information.

"And other things like when our facility, the nurses are careless, if you work with wounds, you've got all those cushions that you're using that got blood. You can't just throw all over, throw, because we are working with kids. Those pieces of cottons, they must put back on their [unclear]. It's supposed to be [unclear] where you put things like needles, all that stuff. It needs our facility to got [sic] those things like that. Not put in ordinary bin, because sometimes a GA (General Assistant) can pull up that dirt in that bin without gloves and then he's going to be contaminated".

(Focus group two participant six)

"Sometimes you take the patient to Red Cross, you sit down with the folder, oh it's MDR patient. But why the nurses not talk to me because she knows mos she was working, why didn't you come to me. You must be careful because of this MDR".*

(Focus group two participant four)

**(Multi-drug resistant TB)*

The RCWs indicated that safety is a primary concern for them, be it that they are facility - based and afraid of poor infection control, or that they are community - based and afraid of being caught in the cross-fire during gang violence. Issues around safety should be addressed to ensure that individuals are kept safe by their

employers and that they continue to feel motivated in the work that they do, as issues of safety are linked to levels of job satisfaction and retention.

4.5.3. *Lack of resources:* A lack of resources is something which most South African health care professionals working in the public service experience. Interestingly, while the RCWs identified that they lack physical resources such as toys and equipment, they also focused on the lack of specialized health services in the communities where they work, which they state often delays the progress of their patients.

“...we are a resource as [name] did say, we are a resource on our own. Yes, so that is great because they can just walk into the clinic and get tested [walk out again]. The problem lies with when we have to give them a referral to the district or somewhere else. You understand? And even with the speech as well, we can provide the services, but the problem is also going to arise that we do not know what is wrong with the child then the doctor needs to diagnose that child with Autism with any other kind of intellectual problem and we do not know about it. So now there is where the problem lies because we can't provide that services. They need to see a professional doctor, they need to see a professional audiologist like [name] at the district hospital and where they can make the hearing aids, because we don't have, we only do the primary care, we're only giving them the primary care”.

(Focus group one participant

five)

“I would say if like uhm if we have like just a few resources that would make it lighter on the clients themselves as in like providing, maybe I don't know how far we are going to get, but I would just like a paediatrician there at the clinic so that like if we identify a problem or a challenge there with one of the children, we set it up for diagnosis, because it's important to have a diagnosis to work with the child as towards their intellectual disability or speech problem, then...you know”.

(Focus group one participant

five)

“Resources I don’t think it’s a problem. The only problem is like transport for our clients. There’s resources we can refer them, but then it’s the transport because most of our clients are in wheelchair or they have like the crutch and also the financial problem. Especially if they have to go like to the clinic or to the doctor to a tertiary hospital or even to the district hospital, then they have to have transport. So now in the community if they have a car if they don’t have enough money because people always overcharge them just to drive them from one place to the other place. They know they need, they have to go, and then the people don’t go. And that is where the problem lies. Now they short of medication, they’re short of a lot of stuff they cannot go for the hearing test, or a hearing aid, they cannot come for the speech and they cannot come to, because we have had from that, we couldn’t come because we don’t didn’t have money. The resources is [sic] there, but then the transport and finances is not there, so that’s the problem actually”.

(Focus group one participant five)

While the RCWs view themselves as valuable community resources, in that they are able to make therapeutic services easily accessible to people in their communities, they remain cognizant of the need for specialized services at community level, as these services are at times difficult for their patients to access. Tertiary level specialised clinics, such as neurodevelopmental clinics, are currently provided at institutions such as Red Cross War Memorial Children’s Hospital and are often inaccessible to those in the communities either due to transportation costs or other financial constraints (Harris et al., 2011). The implication of delayed onset of treatment for patients can have significant negative outcomes on the efficacy of rehabilitation (Godecke et al., 2014). The specialist health care professionals working at these clinics can provide a diagnosis such as Autism for example, for a child who a RCW might see for therapy. Having a definitive diagnosis allows the RCW to appropriately counsel and educate the family of the child and allows for intervention to be more tailored to that specific individual and their family.

“Uhm, when we go to our clients, we try what we have, like for instance if I want my client to count I will take these doppies, the different colour doppies for the children, then I will use that or I will bring a stick. But there’s like other things that we really need, like*

the dumbbells or the theraband we don't have things like that. We have to improvise ourselves".

(Focus group two participant one)

- *doppies* are bottle top caps or lids

"In our facility we don't have others, like standing frames, because it's supposed to got [sic] different sizes of, so that patients can fit in that, we only got one, but that's not enough, because it's not all the patient that fit in that walking frame. So, we need more different type of walking frames, so that it can be easy to".

(Focus group two participant

six)

From the above excerpts one can see that RCWs identified both physical resource allocation and human resource allocation as challenges in their work. These challenges were reported across both groups and reiterated by RCWs from different work settings. The RCWs reported that having not only adequate, but also appropriate, physical and human resources is pivotal to providing the most optimal rehabilitation to their patients.

4.5.4. *Feeling undervalued*: All employees need to feel valued and appreciated to remain motivated. There is a stark contrast when comparing the earlier views of RCWs in terms of their perceived value within their communities and the work they do, to the current sub- theme of feeling undervalued. Despite the significance of the work of the RCWs, as well as the appreciation they receive from their communities and peers, they feel unappreciated by their managers and the Western Cape Department of Health (WCDoH).

"I'm going to be straight because this is just how I feel. I feel even though we love our work, we are not, the work is not recognised, or we don't get that recognition as to well done, great work. Or we don't even get acknowledged as being good workers. So that means if you give praise to somebody that's done well, that one

person would do better then, or work like, you know? So, I feel we are very under, okay not undermined, but ja say like a little bit undermined and don't get fully praised for what we are doing. Also, financially as well, so I'm not going to make anything about that, because I just feel what we get is very little in what we do".

(Focus group one participant five)

We were in varsity for 3 years. It's also not only about money we just feel we're not being appreciated. There's no like well done, or things like that or a reward. Even if we have to go on an outing we have to pay out of our own pocket. And what happens, you deal day to day with a lot of issues in the community. You go home, you are, we are human beings, you go home to your own house, to your own family with still of that né. It's not everything that will be erased. Now you have a different way with your children. The outcome is you shout at them, things you've never done before. You get angry, because you have, there's no place that you can go, if you go you have to pay. There's no place that okay, this is for the RCW's, we're going to spoil them, we take them away for a weekend without your husbands without the children. We're in the community every day, it's a different, every day is different. There's a home-based carers day, but there's no RCW day. You know, and we feel that actually, because they are being appreciated. They are being acknowledged. They are being said like thank you for your hard work. Whereas we, we just have to do the work and not, and so we feel very much unappreciated. There's no acknowledgement.

(Focus group one participant seven)

"And it's not to say that we don't like the work that we're doing. I like it, you know, I've always been community orientated, it's just that I feel very much unappreciated".

(Focus group one participant

seven)

The RCW also explained that they feel stressed and often take these stressors home with them, as can be seen in the excerpt below. This excerpt highlights the perception that they cannot access the support that they need in order to cope with these stressors.

“And I mean when people come, they are always speaking about support that is needed for everything and everyone, but the support for the RCW just doesn’t come along. That doesn’t get acknowledged, I mean the amount of work that we do on a day to day basis, it’s hard, but at the end of the day you’re sitting with all that emotional baggage, all that tiredness and you’ve got nowhere nothing to offload from and tomorrow one needs just to be fresh and just keep going on the next day. So we think that lacks really in our environment”.

(Focus group one

participant four)

These excerpts show clearly that RCWs feel overlooked and unappreciated. Their perception is that they do not get sufficient recognition, support or remuneration despite the important role they play in providing rehabilitation services to their communities.

Rehabilitation Care Workers play a vital role in their communities yet experience many different challenges. These challenges include: training gaps, a lack of physical and human resources, safety concerns and feeling undervalued by the system that employs them. Considering the large scope of services that RCWs provide and the community concerns they face daily, it is important for a safe, supportive and nurturing work environment to be created to enable them to continue to provide a valuable service to patients and communities.

4.6. Summary

The themes identified during the data analysis process contributed toward the development of the plot of 'vital role players'. The RCWs feel that they play an invaluable role not only in their communities but also in the rehabilitation teams they form part of. The RCWs provided rich, detailed information regarding the facilitators and supportive factors they experience, but also provided insight into some of the challenges they face daily. The next chapter discusses the themes in relation to existing literature.

Chapter 5

Discussion

5.1. Introduction

This chapter will explore the themes which emerged from the focus groups with RCWs within the context of relevant literature. By exploring the perceptions of RCWs, there is an opportunity to make suggestions to stakeholders such as site managers; rehabilitation practitioners working with RCWs; the University of Cape Town RCW curriculum advisers as well as the Western Cape Department of Health (WCDoH), on how the RCW training and service can be strengthened in the future.

5.2. Rehabilitation Care Workers form vital role players in the communities where they work and in the rehabilitation teams they form part of

Rehabilitation Care Workers perceive themselves as more than just mid-level healthcare workers. They see themselves as 'vital' individuals who have immersed themselves in their communities, going above and beyond their professional duty in their provision of service to patients and their families. From the current study it emerged that through their work, they have forged a place for themselves in health care service teams in contexts where rehabilitation professionals are scarce and over-burdened. The empirical research that has been conducted in low and middle-income countries indicates the value of alternative cadres in health service provision by emphasising the impact that these individuals are able to have on the health status of communities (Mannan et al., 2012). This positive impact has prompted many low and middle-income countries to increase investment into community health worker programmes (Naimoli et al., 2014). By strengthening the current RCW program in Cape Town, the RCW has the potential to be a beneficial addition to the health care team, and in doing so strengthening the current public health care system and move South Africa forward towards the goal of health care for all as part of the Healthcare 2030 plan.

The "logic model" created by Naimoli et al. (2014) suggest that the interaction between motivators and challenges experienced by Community Healthcare Workers (CHWs) has a significant influence on CHW performance. Naimoli et al. (2014) explain that a significant challenge of CHW programs is ensuring the sustained, optimal performance of this important cadre of health care worker. By employing the logic model to CHW programs, it encourages a collective understanding of the connections between these influencing factors and their impact on the CHW program

and the workers themselves. Having insight into the relationship between these intrinsic and extrinsic factors will improve the sustainability of the RCW program by better understanding the positions of the RCWs and by providing insight into how the challenges they experience can be overcome. In subsequent sections of this chapter facilitators (in the form of intrinsic motivators) and barriers (in the form of challenges) identified by the RCWs will be described.

5.3. Facilitator: RCW position and value as an intrinsic motivator

The RCWs position and value can be viewed as an intrinsic motivator was deemed to be a facilitating factor to the provision of services services. Intrinsic motivation was considered to have a positive impact on the job satisfaction of RCWs as it allowed them to have a sense of contentment in their jobs despite the challenges they face (Ojaaka et al., 2014). The sub-theme of 'community servant' emerged strongly as RCWs have an inherent need to serve their communities, which has allowed them to become advocates for their patients. Their support to families, (and subsequent impact on patient and families well-being) reaches beyond therapy sessions, as illustrated in the case where one RCW assisted her patient with getting his job back after being dismissed by his employer due to his rehabilitation needs. Each one of the participants entered the field because they identified a need in their communities and felt that they could contribute to alleviating this need.

Jaskiewicz and Tulenko (2012) suggest that CHWs have become integral members to the health care work force and are a necessary measure to achieving the Millennium Development Goals (MDGs). One can subsequently infer that RCWs also have an important role to play in South Africa's achievement of the Sustainable Development Goals (SDGs) outlined by the United Nations, as these goals emphasise the need for greater attention to be focused on vulnerable groups such as women, children, youth, the elderly, people with disabilities, and displaced persons (United Nations, 2015). Using the skill of a RCW will contribute to the sustainability of community-based health initiatives to reach these marginalized individuals in South Africa, by increasing coverage of health care services, in light of the critical shortage of rehabilitation professionals in the country. Results of the studies by Campbell et al. (2012) and Zulu et al. (2014), emphasise the positive impact that motivation and exacting positive change on a community in need has on

the job satisfaction and retention of CHWs. So it is clear that being able to influence communities is seen as an intrinsic motivator by RCWs while at the same time being a beneficial strategy for achieving both the MDG's and UHC.

A strong and clear message that emerged from the discussions is the great sense of pride that RCWs experience in their roles as RCWs. The RCWs spoke about highlights they have experienced and how seeing their patients succeed has motivated them to continue their work. Seeing these successes makes them aware of their importance as a member of a rehabilitation team. It allows them to see their value and allows them the opportunity to contribute to bettering the life of another. This intrinsic motivator (the feeling of doing an important job) was also deemed a significant factor in predicting job satisfaction in the study by Campbell, McAllister and Eley (2012), which looked at the influence of motivation on the retention of workers in the rehabilitation and allied health services. A study conducted by Ojaka et al., (2014) also identified intrinsic motivation as a key indicator for the job satisfaction amongst CHWs in Kenya. In the study conducted by Zulu, Kinsman, Michelo & Hurtig (2014) which looked at the experiences of community health assistants in Zambia, it was identified through in-depth interviews that passion and exacting visible change in their communities is often what keeps community health assistants motivated despite facing workplace challenges. The RCWs expressed feeling gratified at the positive impact they have on their patients and communities. This ability to exact positive change has led to a sense of pride in the work they do. Thus, the RCWs sentiments correlate with these findings in that the ability to bring about positive change in their community is what encouraged them to explore this career path. Seeing these successes makes them aware of their importance as a member of a rehabilitation team. It allows them to see their value and allows them the opportunity to contribute to bettering the life of another.

The RCWs communicated that ill or disabled members of their communities were neglected and marginalised and it was often this aspect which spurred them to get involved and "better" their communities. Community was a word which was mentioned consistently, emphasising its value to the RCWs. The RCWs also expressed the obligation and duty they feel to reduce the overall stigma and poor health seeking behaviours of those with disability. This sense of obligation to better

the health of those in their communities has lead the RCWs to advocate on behalf of their patients with disabilities, ensuring better access to available services and better integration into their communities. One of the first tasks RCWs do when receiving a new patient is to complete a community profile which lists all resources in an around the patient's home. Being aware of such resources enables RCWs to access them on behalf of their patients. Luruli, Netshandama and Francis (2016) explain that CBR centres on the integration of persons with disability and poor health into their communities. From the data it emerged that the RCWs standing in the community, allow them to achieve this by accessing resources and services for their patients that the patients themselves may not know exist or may have difficulty accessing.

RCW are members of the rehabilitation team. In their scope of practice, RCWs are required to work under the supervision of rehabilitation professionals. Lehmann et al. (2009) explain that task-shifting is a key component to a successful CHW program. The success of task-shifting relies on integrating the roles of new cadres, changing scope of practice and regulatory frameworks, enhancing training infrastructure and engaging all parties regularly (Lehmann et al., 2009). Kessler, MacRae & Dyer (2009) further explain that not only should the new cadre's roles be clearly articulated, but that all members of the team need to have clearly defined roles. It is for this reason important to clearly specify the roles of RCW and rehabilitation professional, and to ensure that these roles are monitored and maintained. The role of community servant is one which is clearly important to the RCW. To ensure the sustainability of the RCW program it is important to develop and harness this intrinsic motivation that RCWs experience as suggested by the 'logic model' created by Naimoli et al., (2014).

In interdisciplinary contexts such as this, task-shifting is often used as a way of transferring skills from one discipline to another. Due to the nature of the RCW program, it was found that rehabilitation professionals transfer their skills to the RCWs, who then transfer their skills to the families of their patients and communities. This continuous transfer of skill contributes to improved health outcomes, community upliftment and also to the sustainability of services.

5.4. Facilitator and Challenge: Scope of practice

Rehabilitation Care Workers (RCWs) often complete a wide variety of tasks. From the transcripts it emerged that although the broad scope of RCW practice was considered a challenge, it was also considered a facilitator. The broad scope of practice was considered a facilitator in that RCWs adopt a Family-Centred Care approach (FCC) which allows them to establish real relationships with families and communities. It emerged from the focus group data that RCWs identified family members as significant stakeholders in patient management. The RCWs naturally gravitate towards exploring the dynamics of family member involvement in the management of their patients and seemed to have adopted a FCC approach to their work. They emphasised the value of continued collaboration between the RCW and the family to ensure maximal the utmost therapeutic benefit for their patients is achieved. The model of FCC is underpinned by continuous engagement between health care personnel and families and has positively impacted the efficacy of health programs (Shields, 2015). The adoption of this approach is therefore considered to be a significant facilitator in the RCWs provision of SLT related activities. In the adoption of a FCC approach, RCWs are able to transfer skills themselves and empower parents and family members in the process. Mannan et al. (2012) indicate that RCWs have the ability to draw in community members and family members, transferring health information in a relatable and understandable manner. They state that this results in an improvement in the health status of communities.

By adopting a FCC approach, RCWs are not only involving families as therapeutic partners but they are also considering the needs of each individual family. From the data obtained from the current study it emerged that RCWs emphasised the need to be empathic towards the individual needs and nuances of each family. The fact that RCWs not only recognise the value of family involvement in rehabilitation but also consider the dynamics of each individual family, emphasises their holistic view of patient management and highlights their position as 'vital role players'.

The RCWs tasks include completing direct rehabilitative services and administrative tasks; facilitating awareness groups; and conducting group therapy and counselling and support groups. This broad scope of practice is also considered a barrier due to the sheer volume of tasks they need to conduct, as well as the fact that they must combine intervention activities from different disciplines into one session. This may

make it difficult for them to feel successful and may negatively impact on the overall quality of the service. While this degree of “instability” causes stress and anxiety, RCWs also reported that this aspect of their work sometimes encourages them to think creatively and on their feet. However, Gopalan et al. (2012) explored factors affecting the job motivation of CHWs in India and reported that having a heavy and broad workload had a significant negative impact on the job satisfaction of this cadre of community worker. This finding is supported by a recent review which indicates that mid-level community health workers can often become overwhelmed when completing a broad range of tasks, and that this negatively affects the overall quality of the service (Jaskiewicz & Tulenko, 2012). However, one it is important to be cognizant of the fact that when there are too many tasks to perform, RCWs may choose to do the tasks they do best; are most comfortable with or those which are the easiest or most feasible to implement.

5.5 Environmental barriers and challenges

For all the positive experiences and factors the RCWs mentioned, they also stressed the challenges they face. Interestingly, all the barriers mentioned by the RCWs were extrinsic factors. This is supported by the findings of Zulu et al. (2014) who found that CHWs face several external workplace challenges, however they report that it is CHW's intrinsic motivation which keeps them satisfied with their work and contributes to the retention of this work force. The extrinsic factors highlighted by this group of RCW included safety; poor infection control within institutions; additional training needs; lack of supervision in the field; poor remuneration and lack of recognition and acknowledgement from their employers and a lack of resources.

Safety concerns emerged as a significant barrier to the work of a RCW. Despite RCWs having different concerns depending on the setting in which they work, the underlying message is that the RCWs do not always feel safe in their work environments. The Rehabilitation Care Workers working in the Primary Health Care sector reported facing gang-violence and high crime rates in the communities where they work. Luthango (2016) explains that the community of Mitchells Plain is significantly affected by gang-violence, with the highest rate of gang-related violence in the South Africa. From the focus group data, it emerged that the RCWs working in this area are often afraid for their lives, as their duties require them to conduct in-

home visits without transport, leaving them to get to their patients on foot or via public transport.

The institution-based RCWs voiced concerns over poor infection control measures and being put at high risk for communicable diseases such as Tuberculosis (TB) particularly Multi-Drug Resistant TB (MDR TB). In South Africa, workplace acquired TB is the third most commonly reported occupational disease (Grobler et al., 2016). Grobler et al, (2016) explain that despite international policy recommendations and national legislative provisions to address workplace acquired TB, generally South African health care facilities do not have adequate or appropriate infection prevention and control measures in place to adequately protect their employees. Although concerns around infection control measures are not isolated to RCWs, it is important to address these concerns as safety has been identified as a significant environmental factor affecting health care worker retention (Rahman et al., 2010).

Studies by De Jonge and Schaufeli (1998) and Ojakaa et al. (2014) highlighted that workplace safety is one of the primary factors affecting job satisfaction and job retention amongst CHWs. All individuals need to feel that their work environments value them as employees and keeping them safe is one such way to do so. Therefore, it is important to consider the impact that it may have on RCW motivation, if they perceive the Western Cape Department of Health (WCDoH) does not prioritize their safety.

A second challenge discussed by RCW is the lack of exposure to in SLT-related activities compared with exposure to activities from the other disciplines. The RCWs identified that they did not receive sufficient SLT teaching in their training program, stating that most of their input and training in this area had been obtained since working alongside qualified SLTs. They also identified that they found SLT-related activities particularly difficult. This may be influenced by the nature of the SLT-related activities they are tasked with, in that these activities require active participation and engagement from the patient whereas, physiotherapy tasks for example can include passive therapy. The RCWs reported that they found providing SLT – related activities to children with Autism particularly difficult, as many of their patients with this diagnosis are non-verbal. A study by Plumb and Plexico (2013) exploring the preparedness of new graduated SLTs to work with children diagnosed with Autism,

showed that majority of the SLTs involved in the study reported that they would have benefited from additional training in the area. Providing SLT related services is one of the roles provided by RCWs and one therefore needs to consider the impact of this, as RCWs expressed concerns regarding adequate supervision in addition to their perception of a lack of SLT – specific training. In addition to feelings of lack of preparedness in treating Autism Spectrum Disorder, Singh et al. (2015) report that newly graduated SLTs have noted the need for further training in Dysphagia and Cerebral Palsy. They state that at the annual meetings of the National Speech Therapy and Audiology (STA) Forum, it was recommended that curricula provide students with more practical learning opportunities in the areas of autism, cleft lip and palate, cerebral palsy, severe disabilities, traumatic brain injuries, adult and paediatric dysphagia, paediatric apraxia and coping in a multilingual environment (Singh et al., 2015). If these areas of an SLT's scope of practice are challenging to new SLT graduates, it is not surprising the RCW indicate similar concerns. Consequently, regular refresher training is needed to ensure that RCWs feel confident in the treatment they administer and to ensure that patients receive the very best care. Alternatively, it may then be useful to propose the idea of limiting the scope of practice of RCWs to activities they are more comfortable with and have received adequate training in.

In addition to the training gaps identified by Rehabilitation Care Workers (RCWs) they felt inadequately supervised by rehabilitation professionals of all disciplines since being employed. In theory, RCWs are required to work under the supervision of a formally trained rehabilitation professional yet sometimes the high workload of rehabilitation professionals does not always allow for adequate supervision. The RCWs request for increased clinical supervision in the context of overburdened rehabilitation professionals is supported by a study conducted by Austin - Evelyn et al, (2016), which looked at CHW perspectives on a PHC initiative in the Eastern Cape of South Africa; here too CHWs expressed the need for increased field-based supervision. These CHWs like the RCWs reported the need for increased supervision while being cognisant of the fact that their supervisors were under-resourced and over-burdened.

Speech–Language Therapy emerged as the most common area of difficulty for RCWs during discussions, highlighting the need for added supervision in this regard.

The fact that RCWs who are facility based felt better supported clinically, speaks to the fact that the rehabilitation professionals working in the PHC sector are limited and overburdened. This notion is emphasised by the fact that SLT distribution has often been concentrated in tertiary settings (Kathard & Pillay, 2013). The Western Cape currently has a population of 6.510.300 with a total of 36 SLTs. (A. De Villiers, personal communication, 19 March 2018; Stats SA, 2017). Currently, there is one SLT providing PHC services in the Mitchells Plain area and one SLT providing services in the Klipfontein area. These two SLTs are responsible for treating patients, over-seeing the RCW program in their areas, providing training to RCWs and also completing all administrative tasks such as statistics and report writing.

Supervision, theoretical and practical support is important to ensure that RCWs do not feel burdened with tasks they need to perform, and that they do not feel overwhelmed about those tasks they feel unsure of. Improved supervision, management and continued education, were identified as influencing factors for the job satisfaction of community health care workers, which in turn influences their desire to continue in the profession (Ojakaa et al., 2014; Campbell et al., 2012). Therefore, while supervision is clearly beneficial, there are insufficient SLT's to adequately address this need. Considering the inadequate number of SLTs currently providing services to the population, a possible feasible solution to this problem would be for the University of Cape Town to provide some form of ongoing mentoring of the RCW once they are employed as RCWs.

Another barrier reported by the Rehabilitation Care Workers is a lack of both physical and human resources. Regarding human resources, they expressed that the health and progress of their communities are negatively influenced by a lack of specialized health care services at community level to provide diagnoses for specific conditions such as Autism. Without a formal diagnosis RCWs find it difficult to provide families with the appropriate advice and information. Not only does a delayed diagnosis negatively impact the RCWs interaction with the patient and family, but it also has a negative implication on developmental and academic outcomes of these children, as without a formal diagnosis they cannot receive the appropriate school placement. Additionally, patients cannot receive adequate medical and therapeutic counselling

and families are unable to process and come to terms with the potential implications of a diagnosis on their child's functioning (Godecke et al., 2014).

In addition to lack of human resources, the RCW also mentioned a lack of physical resources. Mayosi and Benetar (2014) explain that South Africa's public sector is severely lacking the physical resources to keep up with the needs of the country. One can see then that a lack of physical resources is not a problem experienced by RCWs alone but by health care professionals as a whole. However, the lack of physical resources as mentioned by the RCWs, has also been described as an extrinsic factor affecting the job satisfaction of CHWs (Campbell et al., 2012). One participant mentioned using bottle tops during therapy sessions to work on counting and colours. One way to potentially overcome a lack of resources would be to provide RCWs with workshops on how to create their own toys using recyclable materials, this is a skill which could then be transferred to the parents or families of their patients.

The RCWs expressed a lack of verbal affirmation for the good work that they do. RCW feel undervalued by their supervisors and the health care system. Despite feeling a lack of appreciation from their supervisors and the DoH, the ability to bring about positive change in their communities has contributed to the passion they have for their work and appears to be sustaining their motivation to continue providing a service. despite feeling. To ensure that RCWs remain passionate and motivated in their jobs it is important to provide them with the necessary recognition of the important work that they do. One RCW suggested that the DoH have a RCW day, where they could feel special and gain a sense of appreciation for the work that they do. The study by Austin-Evelyn et al. (2016) suggests that other ways to affirm that the RCWs are valued and appreciated would be to potentially introduce fringe benefits such as medical aid and pension to close the perceived gap between the allied health professionals and the RCW and to ensure that RCWs are integrated into the broader health care system. This links with the final challenge raised by RCW, that of remuneration.

The RCWs felt that their remuneration does not reflect their contribution to the communities. Having received a qualification from a reputable university, such as

UCT, and having such a broad impact on their communities gives them a sense that they deserve a higher salary. When exploring the intrinsic and extrinsic motivators affecting the retention of CHWs, Campbell et al. (2012) identified that competitive salary levels was one key factor in job retention. Rahman et al. (2010) report similar findings and state that adequate monetary compensation is a vital factor related to staff retention. To reduce a high turn-over of this valuable cadre of health care worker, it is consequently important for managers and employers to ensure that the salaries offered to RCWs are competitive and appropriate for the work they do. In the resource-constrained context South Africa finds itself in, it may be feasible to collaborate with private funders and Non-Government Organisations (NGOs) to access additional funding to offer RCWs competitive salaries.

5.6. Summary

This chapter explored RCWs as 'vital role players' and expanded on the themes which arose from the focus group discussions in relation to current literature. The themes which emerged from this focus group align with empirical evidence from other developing countries such as Zambia and India. Furthermore, there appears to be significant overlap in the facilitators and barriers identified across the different groups of health care workers.

Chapter 6

Conclusions

6.1. Introduction

The primary purpose of this research study was to explore the facilitators and barriers that Rehabilitation Care Workers (RCWs) encounter in the provision of Speech-Language Therapy (SLT) related services. In this chapter this information is compiled into recommendations for key stakeholders. The findings indicated that RCWs have a considerable impact on health by providing a scarce rehabilitation service to those residing within the Mitchells Plain/ Klipfontein sub-district. In doing so, they contribute to South Africa's progress toward achieving health care for all and reaching the Healthcare 2030 Plan and the Sustainable Development Goals (SDGs). While their contributions have been significant, they often encounter challenges in providing these services.

Due to the critical shortage of health care professionals, particularly rehabilitation professionals, South Africa has been unable to effectively implement PHC and CBR. Evidence has shown the positive impact that an alternative cadre of health care worker can have on reaching the goal of UHC, ensuring access to health care and the continuum of care within low resourced countries. To ensure the effective implementation of PHC and CBR strategies, it is vital to monitor and evaluate the current service and therefore imperative to explore the new role of the RCW. Due to the infancy of the RCW cadre and to effectively evaluate the RCW service, it is important to identify the factors which make their work easier and those which form barriers and suggest ways for the RCW service to be improved. With only 2679 registered SLTs in the country, it is important to explore the nature of the collaboration between SLT's and RCWs in providing rehabilitation services related to this discipline. Furthermore, the research relating to this cadre is still limited, therefore emphasising the need for additional research studies which focus on this

group of health care worker. The recommendations provided in this chapter are suggestions to address some of these challenges.

6.2. Recommendations to the Western Cape Department of Health (WCDoH)

6.2.1 Recommendation One: Developing effective supervision models

Extensive research has been done on various cadres of community health worker indicating the need for improved field-based supervision and the negative impact that a lack of supervision has on job satisfaction of CHWs (Ojakaa et al., 2014; Campbell et al., 2012). One means of improving RCW supervision is to strengthen the MDTs working in these sectors by increasing the number of rehabilitation professional posts available. Multi-Disciplinary Teams (MDTs) within the Primary Health Care (PHC) and Intermediate Health Care sectors are lacking due to an inadequate number of posts for rehabilitation practitioners. Another method is to develop and circulate clear policy, legislature and protocols regarding the RCW scope of practice in which the supervisory role of health care professionals is addressed. The final method proposed here is to develop and test effective evidence-based supervision structures which empower both RCWs and their professional mentors.

6.2.2. Recommendation Two: Improving safety measures

Safety is one of the primary indicators for health care worker retention (Campbell et al., 2012; Rahman et al., 2010). To ensure we retain these valuable members of the health care system the WCDoH should consider implementing measures to address the unsafe working conditions many RCWs experience. The WCDoH need to consider safe methods of transportation for RCWs working in the PHC setting to avoid them walking through unsafe areas during home visits. Additionally, training on infection control practices and management of biohazardous material needs to be conducted at the workplaces of RCWs and could also be considered for inclusion in the RCW formal training program. Health care facilities need regularly updated policies and procedures relating to organizational health issues and all staff should

receive adequate training on these topics. Furthermore, RCWs should receive regular health screening for communicable disease such as Tuberculosis (TB) as recommended by Grobler et al. (2016).

6.2.3. Recommendation Three: Considering remuneration packages

The RCWs felt unjustly compensated by the WCDoH as they viewed themselves as providing a fundamental service with workloads which are often too high. It is recommended that the WCDoH relook at the salary levels of RCWs and make allowances for benefits such as medical aid and pension funds to be standardised across employees and institutions as suggested by Campbell et al. (2012) and Rahman et al. (2010).

6.2.4. Recommendation Four: Improving support services

Due to the impoverished communities that many RCWs work in they are often exposed to less than desirable situations. Patients often come from traumatic backgrounds and often turn to the RCWs for empathetic listening and support. The RCWs expressed that they take these stresses home with them and indicated that they do not know how to cope in these situations. Emotional support and access to counselling is needed to ensure these individuals do not suffer from burnout and undue work-related stress (Haq, Iqbal & Rahman, 2008). Rahman et al. (2010) explain that ensuring the emotional and psychological well-being of community health workers is an essential mechanism for ensuring their retention in the field. A motivated, driven and passionate workforce is central to ensuring adequate health care services in any setting but is particularly important in low-middle income countries like South Africa, where resources are few and community violence, crime and drugs are rife.

6.3. Recommendation to the University of Cape Town (UCT)

6.3.1. Adaptations to the training curriculum:

The RCWs expressed inadequate theoretical and practical SLT input during their training programme. Furthermore, the focus group discussions highlighted the need

for ongoing training from all rehabilitation professionals, but especially SLTs once RCW are employed. One needs to consider the benefit of additional SLT training for RCWs and the impact this will have on their confidence to provide the appropriate treatment for their patients (Rahman et al., 2010; Campbell et al., 2012). Furthermore, adaptations to the scope of practice of RCWs may be considered, to restrict RCW unsupervised exposure to challenging areas of practice such as Dysphagia management and working with children with diagnoses such as Autism Spectrum Disorder.

6.4. Recommendations for future research

6.4.1. Practice guidelines

The research study has highlighted the need to conduct research which will lead to the development and adoption of formal practice guidelines for RCW including issues surrounding supervision. In order for the RCW service to be strengthened clear guidelines need to be developed and regularly adapted as the service changes and expands (Clarke, 2015). Petrick et al. (2002) suggest that the lack of practice protocols and standards have made the evaluation and supervision of Community Based Rehabilitation (CBR) programmes more difficult. The development of such guiding documents will enable rehabilitation professionals to monitor and evaluate their RCW programmes, ensuring that the service is in keeping with the latest legislature and recommendations. Such monitoring is essential in the review and adaptation of new programmes and initiatives. Future research could therefore focus on evaluating the effectiveness of different supervision models on RCW knowledge and skill.

6.4.2. Rehabilitation professionals' perceptions of the role of RCWs within an MDT.

The current research study alluded to the fact that RCWs are unsure of their role within the rehabilitation team as some clearly stated that the rehabilitation professional needs to see the patient first, yet others stated that this is not always the case as they are sometimes the first one to see a patient. This study did not document rehabilitation professionals' perceptions of the role of RCW and so the power dynamic between the two groups of professionals could not be explored. Documenting the rehabilitation professionals' perception of the role of the RCW

within an MDT will contribute to developing a standard supervision structure for RCWs and will assist in defining RCWs scope of practice. A more in-depth analysis of the power dynamic between the rehabilitation professionals and the RCWs will provide insight into the working relationship between these individuals, allowing for any problematic areas to be identified which in turn will harness a more improved working relationship between these integral members of the MDT. Establishing these clearly defined roles may also solve any conflicts which may arise between the role and function of the RCW and the role and function of the professional.

6.4.3. Creating a clear distinction between CHW; CRW and the RCW.

There is currently no clear conceptual distinction between CHWS, CRWs and RCWs. Often terms such as CHW, CRW and RCW are used interchangeably depending on which country the study is conducted in. Providing conceptually different definitions for this cadre of HCW would be beneficial. Research using consensus methodology amongst experts may provide a first step to achieve this goal. This would pave the way for comparative research designs investigating aspects of scope of practice, job retention and job satisfaction amongst this cadre of health care worker.

6.4.4. Exploring RCWs perceptions of where they fit within the generalist VS specialist debate:

As RCWs perform duties related to several rehabilitation professions, it would be beneficial to explore their perceptions of whether they consider themselves to be specialists or generalists within the rehabilitation field. This would in turn provide insight into the dynamic between the RCWs and the rehabilitation professionals who work alongside them. This will encourage improved communication and understanding within the MDT and also help to better define the role of the RCW within this team. Better understanding this dynamic will also help to inform the training and mentoring RCWs received during their training programs, and also when employed.

6.5. Strengths of the study

The following can be viewed as strengths of the study:

- The projects findings were documented using the COREQ guidelines (Tong, Sainsbury and Craig, 2007). This ensures the comprehensive reporting of findings and to support the replication of this study.
- The use of audio recording and transcription allowed the researcher to accurately reflect the participants' views than contemporaneous researcher notes. In addition, participants checked the transcript for accuracy which heightens the credibility of the research findings.
- Investigator triangulation is a strength of this research study. Three researchers were involved in the development and refinement of the themes and resultant coding rubric. Investigator triangulation increases the robustness of the identified themes.
- The researcher's efforts to include all RCW who met the selection criteria also contributes to the findings being representative of the perceptions of the RCWs working in the Mitchells Plain /Klipfontein sub-district.

6.6. Limitations of the study

The limitations of the study are as follows:

- Demographic data such as employment history and area in which RCWs live were not formally collected during this study and may have been helpful as these factors would provide more information regarding the current sample of RCWs which may have been helpful when describing RCWs perceptions.
- As purposive sampling was used during this research study, the findings obtained cannot be generalised to any other group of RCWs or groups trained by UCT.
- Focus groups were held with only RCWs and not the rehabilitation professionals who work with them, thus limiting the understanding of the role and value of RCWs to that described by the RCWs themselves.
- Although identifying themes were undertaken by 3 individuals (the researcher and her 2 supervisors) the data was not independently coded by an outside coder to determine the reliability of the resulting coding rubric and themes.

- The nature of descriptive design and inductive data analysis means other researchers could have created different themes and sub-themes from the same data.
- Combining focus groups with individual semi-structured interviews may have provided a greater access to personal experiences of individual participants.

6.7. Summative statement

Rehabilitation Care Workers are making a significant contribution to helping South Africa achieve its Healthcare 2030 plan. They have become invaluable members of the health care system and have forged a niche for themselves in the rehabilitation teams that they form part of. They perceive themselves as integral members to these teams and vital role players in their communities. Despite their positive contributions, they are faced with several challenges on a daily basis which need to be addressed in order to improve their ability to provide a quality service and allow them to remain motivated to serve their communities.

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Appendix A – Informed consent:



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Informed Consent Form

Dear participant

Information about a research study investigating: The facilitators and barriers experienced by Rehabilitation Care Workers (RCWs) in providing Speech – Language

Therapy related activities to the communities where they work (HREC number: 095/2016).

I am Masters' student currently completing my post graduate degree with the University of Cape Town. As part of my degree I am required to conduct a research project. This study aims to explore and describe the experiences of RCWs in providing Speech-Language Therapy related activities in the communities where they work. As a therapist working closely with RCWs it is important to know the challenges and facilitators that you face on a daily basis and how prepared, equipped and supported you feel in doing your job.

As you are the individuals tasked with providing this service, your feelings and experiences are of utmost importance and value. The information collected will allow Speech –Language Therapists working alongside you to better support and facilitate your development as a RCW. The information gathered may also be used to adapt the current RCW curriculum which may improve the experiences of future RCWs.

You have been invited to participate in this research study as it is open to all RCWs working within the Mitchells Plain/Klipfontein sub-structure. If you agree to participate, you will be invited to join a focus group discussion with 5-7 of your colleagues. The focus group discussion will take no longer than 2 hours with refreshments served before starting the discussion. The questions asked will focus on your feelings and experiences as an RCW. All information is confidential and will only be used for the research project. The focus group discussion will be audio and video recorded. Video recording will be used to capture any details which might not be easily noticed by audio recording (e.g. body language). It will also allow the researcher to identify when another participant speaks. This recording will be stored in a secure place and will not be available to anyone other than the researcher, her research supervisors and the research assistant. All audio and video recordings will be deleted once the information has been analyzed.

Participation in the study is completely voluntary and there will be no consequences if you do not take part. The focus group discussion will be informal and you will not be required to answer any questions that you are not comfortable with. If you at any stage feel that you do not want to participate you are free to withdraw at any time.

If you choose to participate and give consent for the researcher to use the feelings and experiences that you have shared, or if you decide not to participate there will be no influence on your current or future employment as a RCW. Any information that you share will not be traceable to you as no personal information will be mentioned in the write up of the study or be shared with anyone else. The researchers will not share any information

mentioned in the focus group, however, the researchers cannot guarantee that fellow participants will not share any information discussed.

There will be no immediate benefit to you and you will not receive any payment for your participation, however the information you share will contribute to a better understanding of the challenges faced by RCWs with the potential to improve your experiences and the experiences of future RWCs. Results of the study may be published in a research journal or presented at conferences. You may request to see the finished paper/presentation by contacting the numbers provided.

Please contact the researcher on the number provided if you need any extra information or if you have any questions about the study that you may want answers for. **You may also contact the Human Research Ethics Committee (HREC) should you have any ethical concerns or questions about your rights or welfare as a research participant. Please find the number below.**

Thank you for considering this invitation to participate in our study.

Salma Higgs (Researcher)

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Faculty Health Science, University of Cape Town

Prof Marc Blockman Chair of Human Research Ethics Committee

Email: marc.blockman@uct.ac.za

Contact Number: 021 406 6492

Informed consent to participate:

I have been invited to participate in the post graduate UCT research study. The information has been read by me or to me and I understand the risks, benefits and my role in participation. I have had the opportunity to ask any questions about the study and have been answered to my satisfaction. I am willing to share my opinions and am aware that the researchers cannot guarantee confidentiality amongst participants but that the researchers undertake not to share any identifying information in the write up of the research project or when talking about the project.

I **give** my voluntary consent to participate in the study

I **do not give** my consent to participate in the study.

I **give** my voluntary consent to **only be audio – recorded**

I **give** my voluntary consent to be **audio and video recorded**

Signature of Participant _____

Date _____



UNIVERSITY OF CAPE TOWN
Faculty of Health Sciences
Human Research Ethics Committee



Room E52-24 Old Main Building
Groote Schuur Hospital
Observatory 7925
Telephone [021] 406 6338 • Facsimile [021] 406 6411
Email: shuretta.thomas@uct.ac.za
Website: www.health.uct.ac.za/fhs/research/humanethics/forms

08 April 2016

HREC REF: 095/2016

Appendix B ~~Dr M Hart~~ **Ethics approval:**

Communication Sciences and Disorders
Health & Rehab
OMB

Dear Dr M Hart

PROJECT TITLE: AN EXPLORATION OF THE FACILITATORS AND BARRIERS EXPERIENCED BY REHABILITATION CARE WORKERS IN THE PROVISION OF SPEECH-LANGUAGE THERAPY RELATED SERVICES (MSc-candidate-Ms S Higgs)

Thank you for submitting your study to the Faculty of Health Sciences Human Research Ethics Committee.

It is a pleasure to inform you that the HREC has **formally approved** the above-mentioned study.

Approval is granted for one year until the 30th April 2017.

Please submit a progress form, using the standardised Annual Report Form if the study continues beyond the approval period. Please submit a Standard Closure form if the study is completed within the approval period.

(Forms can be found on our website: www.health.uct.ac.za/fhs/research/humanethics/forms)

Please quote the HREC REF in all your correspondence.

Please note that the ongoing ethical conduct of the study remains the responsibility of the principal Investigator.

Please note that for all studies approved by the HREC, the principal Investigator **must** obtain appropriate Institutional approval before the research may occur.

The HREC acknowledge that Salma Higgs will also be involved in this study.

Yours sincerely

PP T. Burges

PROFESSOR M BLOCKMAN
CHAIRPERSON, FHS HUMAN RESEARCH ETHICS COMMITTEE

Federal Wide Assurance Number: FWA00001637.

Institutional Review Board (IRB) number: IRB00001938

This serves to confirm that the University of Cape Town Human Research Ethics Committee complies to the Ethics Standards for Clinical Research with a new drug in patients, based on the Medical

HREC REF 095/2016

Research Council (MRC-SA), Food and Drug Administration (FDA-USA), International Convention on Harmonisation Good Clinical Practice (ICH GCP), South African Good Clinical Practice Guidelines (DoH 2006), based on the Association of the British Pharmaceutical Industry Guidelines (ABPI), and Declaration of Helsinki (2013) guidelines.
The Human Research Ethics Committee granting this approval is in compliance with the ICH Harmonised Tripartite Guidelines E6: Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95) and FDA Code Federal Regulation Part 50, 56 and 312.

Appendix C: Approval from WCDoH Strategy and Health Support Department:



**Western Cape
Government**
Health

STRATEGY & HEALTH SUPPORT

Health.Research@westerncape.gov.za
Tel: +27 21 483 6857; fax: +27 21 483 9895
5th Floor, Norton Rose House, 8 Ricbeek Street, Cape Town, 8001
www.capegateway.gov.za

REFERENCE: WC_2016RP21_452
ENQUIRIES: Ms Charlene Roderick

University Of Cape Town

Rondebosch

Cape Town

7700

For attention: Dr Michal Harty

Re: An exploration of the facilitators and barriers experienced by Rehabilitation Care Workers in providing Speech – Language Therapy related activities

Thank you for submitting your proposal to undertake the above-mentioned study. We are pleased to inform you that the department has granted you approval for your research.

Please contact the following people to assist you with any further enquiries in accessing the following sites:

Mitchells Plain CHC

Zethu Xaple

021 391 5820


Kindly ensure that the following are adhered to:

1. Arrangements can be made with managers, providing that normal activities at requested facilities are not interrupted.
2. Researchers, in accessing provincial health facilities, are expressing consent to provide the department with an electronic copy of the final feedback (**annexure 9**) within six months of

completion of research. This can be submitted to the provincial Research Co-ordinator
(Health.Research@westerncape.gov.za).

3. Please Note that access is granted until the end of 30th December 2016 due to facility renovations.
4. In the event where the research project goes beyond the *estimated completion date* which was submitted, researchers are expected to complete and submit a progress report (**Annexure 8**) to the provincial Research Co-ordinator
(Health.Research@westerncape.gov.za).
5. The reference number above should be quoted in all future correspondence.

Yours sincerely



Dr Hawkridge

DR A HAWKRIDGE

DIRECTOR: HEALTH IMPACT ASSESSMENT

DATE: 17/5/2016.

CC

P OLCKERS

DIRECTOR: MITCHELLS PLAIN / KLIPFONTEIN



UNIVERSITY OF CAPE TOWN

Faculty of Health Sciences



Department of Health and Rehabilitation Sciences

Division of Communication Sciences and Disorders

F45 Old Main Building, Groote Schuur Hospital, Observatory 7925

Tel: +27 (0) 21 406 7667

Fax: +27 (0) 21 406 6323

Internet: www.uct.ac.za

19 August 2015

Dear Mrs. De Wet

Re: Request to conduct research with Rehabilitation Care Workers (RCWs).

I am a Speech – Language Pathology Master’s student from the University of Cape Town. I hereby request permission to conduct research with Rehabilitation Care Workers (RCWs) employed within the Mitchells Plain/Klipfontein sub-structure. The title of my research study is “An exploration of the facilitators and barriers experienced by Rehabilitation Care Workers in providing Speech – Language Therapy related activities”. Ethical clearance has been obtained from the University of Cape Town’s Faculty of Health Sciences Human Research Ethics Committee (ethics reference number HREC 095/2016). Permission has also been obtained from the Western Cape Department of Health (WCDOH).

The study aims to describe the facilitators and barriers that RCWs experience in providing Speech-Language Therapy related activities to the communities they serve. The following objectives will help to achieve the abovementioned aim:

To describe:

1. How contextual factors (i.e. facility, resources, work space etc) in the workplace influence the provision of Speech – Language Therapy related services.
2. How personal factors (i.e. time management, dealing with stressful situations, language barriers etc) affect the provision of Speech – Language Therapy related activities.

3. Whether support structures are available to RCWs and how these support structures influence the provision of Speech – Language Therapy related activities.
4. How specific challenges experienced in the workplace are overcome.

The focus groups will take place at a time and venue which is suitable and convenient for all participants. I kindly request the use of a room for the focus groups at the University of the Western Cape Student Research Centre as it will be easier for the prospective participants to access. The entire focus group process is not expected to exceed 2 hours. Should any feelings of distress arise during the focus group, the contact details of a predetermined support individual will be provided to the participants. The participant's confidentiality will be ensured as any identifying information will not be reported in the write up of this research study. Once the research study has been completed, results will be analysed and computed into a thesis document that will be made available to you.

RCWs will be allowed to the opportunity to share their views, experiences and feelings regarding service provision in a focus group setting. The results of this study may contribute to identifying training gaps as well as areas where further support is needed to better service delivery. Participation is voluntary, and participants will be allowed to withdraw at any stage. The focus of the study is on what and how factors influence the provision of Speech – Language Therapy related services by RCWs.

Ethical principles as mentioned in the Declaration of Helsinki (2013) will be adhered to during the study; autonomy, anonymity and confidentiality will be upheld. The study is considered to be of minimal risk to participants. All participants who meet the selection criteria will be invited to participate and the results will be made available to you for your perusal on completion of the study.

Participants and the site will not be liable for any costs and no payments will be made for participating in the study. There will be no additional work required from staff at the sub-structure office.

Please do not hesitate to contact myself or the project supervisors should you have any questions or concerns.

Salma Higgs (Researcher)

Email: s.higgs990@gmail.com (c) 074 207 9940

Dr. Michal Harty (Research Supervisor)

Email: Michal.harty@uct.ac.za (c) 082 461 0553

Lecturer: Division of Communication Sciences and Disorders

Faculty Health Science, University of Cape Town

....., Rehabilitation Co-ordinator for the Mitchells
Plain/Klipfontein sub-structure,

Vivienne Norman (Research co-supervisor)

hereby **grant** permission for the study;" An exploration of the facilitators and barriers experienced

Email: Vivienne.norman@uct.ac.za

by Rehabilitation Care Workers in providing Speech – Language Therapy related activities" to be
conducted.

Lecturer: Division of Communication Sciences and Disorders



Faculty Health Science, University of Cape Town

hereby **do not grant** permission for the study; "An exploration of the facilitators and barriers

Prof Marc Blockman Chair of Human Research Ethics Committee

by Rehabilitation Care Workers in providing Speech – Language Therapy related
activities" to be conducted.

Email: marc.blockman@uct.ac.za

Contact Number: 021 406 6492



The nature and purpose of the study has been fully explained to me and I have been given the
chance to ask questions and gain further information on the study.

Your participation will be greatly appreciated.

Date: 17.06.16

Please sign below if permission is granted:

Signature: L de Wet

I,, Rehabilitation Co-ordinator for
the Mitchells Plain/Klipfontein sub-structure,



Appendix E: Interview Guide:

Interview guide

1. Opening Question:
Where do you work? Why did you become a RCW?

2. Introduction Question:

Tell me about your experiences as a RCW.

3. Transition Question:

Tell me about one highlight and one disappointment you have experienced thus far as a RCW.

4. Key Questions:

4.1. Describe what activities you perform regularly.

4.2. How do environmental factors where you work in influence how you provide SLT-related services to you patients, their families or the community?

-When I say environment I think of things like facilities where you work, resources available, working space, salary etc. Your list may be a little different and that's fine too.

Probe: Do you feel that safety is also an issue? Can you tell me more?

4.3. What personal skills have helped you to provide SLT-related services?

Probe: is there any skill that you wish you had or could learn to help you provide SLT-related services?

- What about skills such as:
- Speaking more than 1 language
- Conflict resolution
- Ways of dealing with stress
- Working within a team
- Time management
- Do you feel these skills will help you to provide a better service? If so, how?

4.4. Describe some of the strengths and weaknesses in your own knowledge in providing SLT-related activities.

- Tell me a bit about how confident you feel in the knowledge that you have?
- Do you feel that you know what normal development involves?
- Do you feel confident in identifying speech therapy related difficulties or problems?
- Do you feel confident that you know what to do when you notice a speech therapy related problem?

- Tell me about how your training equipped you to provide SLT-related services?
- Tell me a bit about your exposure to different situations and cases
- How do you feel about having enough opportunity to practice the skills you have acquired?

4.5. Des
 Describe strengths and weaknesses in the clinical skills that you have to provide SLT-related activities.

- How about running a group therapy session?
- Tell me more about counseling or feedback to patients or parents
- Tell me about documenting patient progress e.g. in files
- Tell me about implementing intervention plans
- Tell me more about promotion within the communities or to families e.g. awareness talks, information sessions
- Tell me about your training
- Tell me about exposure to different situations and cases
- Can you tell me more about the opportunity to practice your skills?

4.6. Can you tell me about the support that you have available to you in providing SLT-related services?

- How easy is it to ask a therapist for support?
- How easy is it to ask a manager for support?
- How easy is it to ask a peer for support?
- Tell me about the opportunities you have to discuss patient related difficulties

5. Are there any other challenges that you experience in the workplace?

6. Have these challenges mentioned been addressed? If so, tell me about how this took place.

Appendix F: Accuracy of transcription form:

Please read through the attached transcription of the focus group that you attended and tick in the appropriate space.

The transcribed focus group data *IS* an accurate reflection of my words and opinions as communicated in the focus group that I attended.

The transcribed focus group data *IS NOT* an accurate reflection of my words and opinions as communicated in the focus group that I attended.

If the data is not accurate, please elaborate on the sections you wish to be modified below and tell us how you would like your views to be edited or augmented:

Name:

Signature:

Thank you very much for your contributions.

Salma Higgs

Appendix G: Coding Rubric:

Theme	Catchphrase	Description	Examples/quotes
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Agents for change	"it's hard, it's tough but at the end of the day we enjoy what we are doing"	There is a great sense of pride and joy in the work that they do and seeing a patient or family succeed.	"...Ja, having worked here in the community ja, you see problems ne, if maybe you see that ow, I did help there because you see the improvement it makes , you feel, it makes you feel ja more motivated "
Community servants	"I'm a community orientated person"	The RCWs have a deep rooted connection to the communities they serve. Most RCWs chose the profession because they felt the need for skills and development in the communities where they live.	"It was always about the community and to educate the community. You can't stop educating because we were sent away to study, to educate us and that made us clever and it make us stronger and to believe what you achieve to become successful. And if you look in the community, the people we touch, it's a success and that for me is the highlight."
RCW activities	RCWs are involved in several aspects of therapeutic intervention, often including administrative tasks, group therapy and counselling	RCWs list the duties they perform.	<i>"Because I was interested to help people in the community and to do ative and passive movement to do activity of daily lives and to facilitate how to dress and cleanse himself for grooming, eating, independently; how to transfer from bed to chair from chair to bedand from chair to toilet and also how to deal with speech clients in the community and also do the community resoruce file the support groups that are around so that I can refer the patient and also make the patient stronger, and also to empower the patient by spiritual if he or she believe by praying and also reading the Bible and also form the small support group to the patient nearby asking permission from the patient and from the family, and also to do audio in the clinic so to test the hearing loss of MDR TB and to do the stats and also work as a team".</i>

Awareness of broad scope	"...we do so much you know we do so much"	RCWs often feel that they are combining a variety of different disciplines in the treatment for one patient.	"I think from my perspective, I won't say that it's something easy. Being an RCW is very challenging like you know, we are a combination of 4 professions and to include that on a day to day basis, it's very hard. "
Integral members of a team,	"we are learning continuously"/ "we work under the supervision"	RCWs need to work under the supervision of a qualified therapist but due to staffing constraints and workload this is not always possible. There is a definite distinction in the collaboration between RCW and therapist dependent on the work setting i.e. (community-based vs facility-based)	"I visit the client after the supervisor, because it's a professional OT or speech go first and give me the goals that I must do for the patient. So I just do the plans for that patient, because I have a clue what I must do. Professionals do first".
Go between formal structures and community	"assist them even if go that extra mile"	RCWs often go the extra mile for their patients, beyond their job descriptions.	"it broadened my knowledge and my skills as well because you go into a home and you have to go holistically and then you find out you're not working with one kind you're working with the whole household. So you try to figure out where you can help so you know you have to have like a community profile, so you know exactly where to go and you try and have interviews for the people that you need to go see to help the family itself, so whether it's like the ward council, whether it's like the police, whether it's like the doctor or the sister whatever the help they need or even the mental health sister..."
Understanding family needs	"and not to be judgemental, it's also a strength when you come into different houses,	RCWs take careful consideration of the nuances of each individual family.	"So I would consider the family, how they feel about everything, take into account, their stresses as well"

	they have different ways and different values"		
Including family as stakeholders in patient management	"and support from the family, because if the family don't understand what are you doing there?"	RCWs have an awareness of the importance of the family of the patient as part of the management team	"and support from the family, because if the family don't understand, what are you doing there?"
Lack of resources	So now there is where the problem lies because we can't provide that services.	RCWs experience a great amount of difficulty working in the PHC system as there are not enough services available at this level of care, waiting lists are long and sometimes the resources are not available.	"The problem lies with when we have to give them a referral to the district or somewhere else you understand? And even with the speech as well, we can provide the services, but the problem is also going to arise that we do not know what is wrong with the child then the doctor needs to diagnose that child with Autism with any other kind of intellectual problem and we do not know about it. So now there is where the problem lies because we can't provide that services. They need to see a professional doctor they need to see a professional audiologist like [Name] at the district hospital and where they can make the hearing aids because we don't have, we only do primary care, we only giving them the primary care.
Safety	" suster maak jou skaars"	There is often a high level of violence in the communities where the RCWs work. The RCWs feel that their safety is not guaranteed in both the community and the facilities.	"So there's a shooting, there was a shooting taking place over the weekend. So now we already know we are ready although we don't stay in that certain area but we know because word gets out there was 2 or 4 who was being murdered or shot like and that is the area we are working in. So we have to be careful how we walk because now it comes any time it can be that time again that it starts. .."
Feeling undervalued	"What do we get?"	Despite the value they see in the work	"and it's not to say that we don't like the work that

		they do RCWs feel deeply undervalued by their employers.	we're doing I like it you know, I've always been community orientated it's just that I feel very much unappreciated"
Training gaps	It's hard	RCWs expressed needing more input regarding SLT.	"...I think most of our problem is that we didn't get information about the speech therapy [in] our training, we only got speech here, so to us it was new things. I would like to learn and learn, and as we get the cases it's when you learn. Oh I have this case now and you go to your OT or Speech Therapist.... I have come across this particular problem so what do I do? I go about it then they will explained to you and then we also have like the [unclear] where you raise uh your concerns about the speech so we need that ongoing like training on speech".